

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

IN RE:

RACHEL A. MAY

License No. 025-0006969

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Docket No. NU71-0507

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Edward G. Adrian, and the Respondent, Rachel A. May, 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.

Statement of Facts

2. Rachel A. May (the "Respondent") of Swanton, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025-0006969. This license was originally issued on or about July 12, 1993 and is currently set to expire on or about January 31, 2010.
3. By way of history, Respondent was reprimanded and conditioned by the Board on or about September 13, 1995 due to numerous medication errors. These errors included failure to administer medications; failure to record that a medication had been administered; administering medications after the medications had been discontinued by physicians; administering a medication that had not been ordered by a physician; incorrect charting; and administering the wrong dosage of a medication. Attachment A.
4. On or about May 8, 2007 in a Statement of Complaint to the Office of Professional Regulation, T.L., an LPN at The Arbors, located in Shelburne, Vermont, stated in part the following:

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- a. On or about the night of December 26, 2006, T.L. received a new vial of Lantus (insulin) for Resident C.H. T.L. placed the new, unopened vial in the refrigerator, and removed the old vial and discarded it. On or about December 27, 2006, Respondent documented administering Lantus to Resident C.H., but T.L. later found that the new vial's flip cap was undisturbed, and therefore was never opened. On or about December 28, 2006, Resident C.H. passed away.
 - b. Respondent failed to administer Depakote to Resident L.G. Day Nurse K.M. became aware of this failure because only two (2) pills were missing from L.G.'s punch card when four (4) should have been missing, and L.G.'s sexual behaviors resurfaced at this time and L.G.'s order for Depoprovera was increased as a result.
 - c. Respondent administered Ativan to Residents B.B. and M.G. two days after another resident passed away because these two residents "missed Edi," the resident who had died. T.L. noted that she had never given either Resident B.B. or M.G. Ativan and stated "it's highly doubtful that they had memory of Edi at this time."
 - d. R.B., an LNA at The Arbors, reported to T.L. that R.B. found Resident A.Y. on the floor. Respondent was asked twice to assess A.Y., but Respondent did not do so. Respondent instructed R.B. to "just pick [A.Y.] up - he's fine."
 - e. The Arbors had copied Resident J.W.'s pill cards to determine whether Respondent was administering medications as ordered. The next day, The Arbors noted that J.W.'s Tylenol had not been given as ordered, although Respondent documented that it was. Respondent stated that she took the Tylenol from another resident's card that was either in front of or behind J.W.'s card in the medication drawer. However, there was no other Tylenol in the entire medication drawer.
5. A review of Respondent's personnel file from The Arbors reveals in part the following:
- a. On or about December 12, 2006, Respondent received verbal counseling for failing to initial fifty-two (52) places on the Medication Administration Record (the "MAR") on or about December 1, 2006, and for failing to administer Bactrim to Resident B.B.
 - b. On or about June 4, 2007, Respondent received a final counsel for giving an incorrect dose of Tramadol to Resident F.C. on or about May 26, 2007; and for packaging an incorrect dose of Depakote and Zoloft for Resident B.O. on or about May 27, 2007. As a result, Respondent was required to have three medication passes supervised; a medication pass audit of Respondent was conducted by a pharmacist; and Respondent was required to complete an online basic proficiency medication administration test.
 - c. On or about June 8, 2007, Respondent made a transcription error.

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- d. On or about June 20, 2007, Respondent received verbal counseling for incorrectly transcribing Resident J.P.'s telephone order for Coumadin on the MAR.
 - e. On or about June 29, 2007, Respondent was terminated for excessive absences.
6. On or about February 29, 2008 in a Mandatory Report of Unprofessional Conduct, D.F., Director of Nursing Services at Haven Healthcare, located in St. Albans, Vermont, stated in part the following:
- a. On or about December 7, 2007, Respondent discontinued the wrong medication for Patient W.T.
 - b. On or about January 19, 2008, Respondent failed to sign out a dose of Ativan.
 - c. On or about January 21, 2008, Resident H.S. told Respondent that H.S. wanted to apply her own prescription cream, so Respondent left the cream with H.S. H.S. never applied the cream. There was no order allowing H.S. to self-administer the cream.
 - d. On or about January 21, 2008, Resident L.L. returned from the hospital with an order to decrease Coumadin, and a new order to begin Percocet. Respondent did not confirm the new order with the physician and did not transcribe the orders. L.L. continued on the previous dosage of Coumadin until on or about January 30, 2008, when L.L.'s PT/INR (lab result) was so high that the Coumadin was discontinued. The error was not found until another party reviewed L.L.'s chart in or around February 2008.
 - e. On or about January 22, 2008, Respondent failed to sign out a Duragesic patch.
 - f. On or about January 23, 2008, Respondent failed to administer a dose of Premarin cream.
 - g. On or about January 25, 2008, Respondent was given a one-on-one inservice with the Assistant Director of Nursing regarding completing admission assessments; notification of physician and family members; infection control; ensuring residents receive necessary care; and the signing out of narcotics and other medications.
 - h. On or about January 27, 2008, Respondent failed to do daily charting on a Level I resident.
 - i. On or about January 31, 2008, Respondent failed to transcribe an order for Morphine Sulfate to the MAR for Resident M.L.

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- j. On or about January 31, 2008, Respondent failed to log in MS Contin on a narcotic sheet.
- k. On or about February 11, 2008, Respondent was placed on probation for thirty (30) days, which included supervision of Respondent's work.
- l. On or about February 23, 2008, Respondent changed a Fentanyl patch a day late.
- m. On or about February 23, 2008, numerous medications were not signed off on the MAR for numerous residents. Moreover, Resident R.D. reported that she did not receive one of her non-narcotic injections that Respondent had documented as given.
- n. On or about February 26, 2008, Respondent was terminated from Haven Healthcare for numerous errors in documentation, medication administration, and transcription, despite teaching and support provided by Haven Healthcare.

Charges

- 7. 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 reason of any cause) which includes performance of unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Rule IV(II)(B)(1); and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(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); and
 - c. 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

- 8. 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

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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.

9. 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.
10. 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.
11. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
12. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
13. 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.
14. 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.
15. 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. A. The Board of Nursing hereby **INDEFINITELY SUSPENDS** the Respondent's license to practice nursing **from the date of entry below**. Before applying for reinstatement, Respondent must either: 1) successfully complete (i.e., receive a passing grade, if applicable) an LPN re-entry program with prior approval by the Board or its designee, and then submit written documentation of completion (certificate of completion, etc.) to verify the same to the satisfaction of the Board or its designee; or 2) successfully complete (i.e., receive a passing grade, if applicable) both a medication administration course and a documentation course with prior approval by the Board or its designee, and then submit written documentation of completion (certificates of completion, etc.) to verify the same to the satisfaction of the Board or its designee. The Respondent's license shall not be reinstated until these prerequisites are met. Once reinstated, Respondent's license will be **CONDITIONED FOR A MINIMUM OF TWO (2) YEARS**. The conditions will be as follows:

- (1) Re-issue of License.

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Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."

(2) Length of Time of Conditions Imposed.

The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes a **minimum of two (2) years** of supervised nursing practice in which she works at least forty (40) hours every two (2) weeks as a practical nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

(3) Notification to Employers/Program Director.

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a nurse and inform them of Respondent's conditional license status.

Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

In the event the Respondent is attending a nursing program which has a clinical portion that involves actual patient care, Respondent shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Stipulation and Consent Order and the ability of the program to comply with the conditions in the Consent Order during clinical experience.

(4) Reports from Employers/Program Director.

Within one (1) month of the date of entry of this Order or within one (1) month of the commencement of nursing employment and **monthly** thereafter, Respondent shall cause every nursing employer the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. This report shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance and attendance.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of her performance and attendance. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead. All Program Director reports shall indicate satisfactory performance and attendance.

(5) Practice Under Supervision.

Respondent shall practice as a practical nurse only in a setting where Respondent has direct supervision for the entire shift by a licensed registered nurse that is in good standing with the Board.

(6) Types of Employment Prohibited.

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Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency or as a private duty nurse or personal care provider during the effective period of this Consent Order.

(7) Out-of-State Practice.

Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent practicing nursing outside the State of Vermont. If Respondent fails to receive such approval before practicing nursing outside the State of Vermont, none of the time spent practicing nursing out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state nursing practice so long as the Respondent can still comply with the provisions of this Consent Order.

(8) Notification of Place of Employment/Personal Address/Telephone Number.

Within five (5) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of her current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment, personal address, or telephone number.

(9) Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), she must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of her Vermont nursing license within thirty (30) days of the date of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

(10) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice as a nurse, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that she has otherwise complied with the requirements for license renewal.

(11) Costs.

The Respondent shall bear all costs of complying with this Consent Order.

(12) Violation of this Order.

If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(13) Completion of Conditional License Period.

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After the conditional license period, the Respondent may petition the Board to remove any and all conditions on her license. The Respondent must present proof that she has fully complied with the terms of this Order.

- 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: 7/2/09

By: [Signature]
Edward G. Adrian
State Prosecuting Attorney

RACHEL A. MAY
RESPONDENT

Dated: June 26 2009

By: Rachel A May
Rachel A. May

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 8-10-09

By: [Signature]
Chairperson

Date of Entry: 8/12/09
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STATE OF VERMONT
VERMONT BOARD OF NURSING

In Re:)
Rachel Ann May) Docket No. NU31-0295
License No. 5969)

STIPULATION AND CONSENT ORDER

NOW COMES the State of Vermont, through Attorney General Jeffrey L. Amestoy, and Respondent Rachel Ann May and stipulate as follows:

1. The Vermont Board of Nursing has jurisdiction to investigate complaints, adopt consent orders, and discipline nurses pursuant to 26 V.S.A. §1582, 26 V.S.A. §1574 and 3 V.S.A. §129.
2. At all times relevant to this matter, Rachel Ann May was a licensed practical nurse, licensed by the Vermont Board of Nursing, holding license number 5969.
3. Respondent voluntarily waives her right to formal charges and a contested hearing before the Vermont Board of Nursing to resolve this matter.
4. At all times relevant to this matter Respondent was employed by the Pine Knoll Nursing Home in Lyndonville, Vermont.
5. From January 28, 1994, through January 26, 1995, Respondent committed numerous medication errors, to wit:
 - a. On or about January 28, 1994, Respondent failed to give medication, Xanax, to a patient at the prescribed time.

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b. On or about April 8, 1994, Respondent failed to record medication, Tegretol, being given to a patient.

c. On or about July 2, 1994, Respondent administered Tylenol #3 to a patient even though the medication had been discontinued by the physician.

d. On or about September 28, 1994, Respondent failed to administer Dulcolax suppository to a patient.

e. On or about October 21, 1994, Respondent gave an ASA suppository to a patient, although it had not been ordered by the physician, and charted on the medication administration record that it had been administered by a different route.

f. On or about December 24, 1994, Respondent administered .5mg Ativan to a patient instead of the 1mg which had been ordered.

g. On or about January 17, 1995, Respondent administered Ativan after it had been discontinued by the physician.

h. On or about January 26, 1995, Respondent failed to administer insulin to two separate patients.

6. The acts and omissions described above constitute unacceptable patient care and constitute grounds for discipline pursuant to 26 V.S.A. §1582(a)(7) (engage in conduct of a character likely to deceive, defraud or harm the public) and 26 V.S.A. §1582(a)(3) (unable to practice nursing competently by reason of any cause) as defined in Vermont Board of Nursing Rule IV(B)(3)(a) (performance of unsafe or unacceptable patient

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care) and Rule IV(B)(3)(b) (failure to conform to the essential standards of acceptable and prevailing nurse practice).

7. The parties agree that the following constitutes fair and reasonable discipline given the above circumstances:

a. The Vermont Board of Nursing hereby REPRIMANDS the license of Respondent.

b. Respondent's license is CONDITIONED for a minimum period of one (1) year commencing with the date of entry of this stipulation and consent order and subject to the following terms and restrictions:

i. The conditions shall remain in place until respondent has completed one (1) year of supervised nursing practice in which she works at least forty (40) hours every two (2) weeks in nursing. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis.

ii. Within five (5) days of the date of entry of this stipulation and consent order, Respondent shall submit her license to the Board of Nursing for a re-issued license labelled "conditioned".

iii. Within one (1) month of the date of entry of this Stipulation and Consent Order and every month thereafter during the one (1) year the conditions are in place, Respondent shall cause every employer she has worked for during the month to submit to the Board an evaluation of Respondent's performance and attendance during that month. This report shall

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be submitted in writing on forms issued by the Board and accompanied by a cover letter on the employer's letterhead. In the event the Respondent attends nursing school, she shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of his performance and attendance. This report shall be submitted in writing on forms issued by the Board and accompanied by a cover letter on the school's letterhead. In the event Respondent is not employed in nursing or attending school during any month or portion thereof, she shall submit to the Board, in writing, a self-report describing other employment or activities.

iv. Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which she practices as a nurse and inform them of her conditional license status. Within ten (10) days of the date of entry of this Stipulation and Consent Order or of any subsequent employment, Respondent shall cause her immediate supervisor to write to the Board, on the employer's letterhead, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with its conditions. In the event Respondent is attending a nursing program, she shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to write to the Board, on school letterhead, acknowledging receipt of the Stipulation and Consent Order and

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ability of the program to comply with its conditions during clinical experience.

v. If Respondent makes any medication errors during the one (1) year that her license is conditioned the Vermont Board of Nursing, after giving Respondent notice and an opportunity to be heard, may revoke the terms of the conditional license and take further disciplinary action. a) Respondent shall bear all costs of complying with this Stipulation and Consent Order.

8. The final disposition of the complaint against Respondent is public and the Board may notify other states of its disposition.

9. The parties understand that the terms of this stipulation and consent order are contingent upon review and acceptance by the Vermont Board of Nursing. If the Board rejects any part of this stipulation then the entire agreement shall be null and void.

10. This stipulation and consent order is entered into voluntarily by Respondent after the opportunity to consult with

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11. legal counsel. Respondent has not been coerced by anyone into signing this stipulation and consent order.

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JEFFREY L. AMESTOY
ATTORNEY GENERAL

Dated: July 21, 1995

by: Eve Jacobs-Carnahan
Eve Jacobs-Carnahan
Assistant Attorney General

RACHEL ANN MAY

Dated: _____

Rachel Ann May
Rachel Ann May
Respondent

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: 9-11-95

by:

Brenda B. Smith
Chairperson

Date of entry: 9-13-95

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