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

IN RE:	)	
TARA M. SCHILDHAUER	)	**Docket No. 2016-172**
License No 025.0086133	)	

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney Elizabeth A. St. James, and the Respondent, Tara M. Schildhauer, LPN, represented by Sandra Strempel, 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.

Statement of Facts

2. Tara M. Schildhauer ("Respondent") of Plattsburgh, New York is licensed by the State of Vermont as a Licensed Practical Nurse ("LPN") under license number 025.0086133. This license was originally issued on April 30, 2012, and expires on January 31, 2018.

3. Respondent has no prior public discipline in the State of Vermont.

4. At all times relevant, Respondent was employed as an LPN by Correct Care Solutions ("CCS"). At all times relevant, CCS was the contract healthcare provider for Chittenden Regional Correctional Facility ("CRCF") located in South Burlington, Vermont.

5. For purposes of this case only, the 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 in a hearing. In addition, while not disputed for purposes of this case, many of the following facts were neither known, nor reasonably should have been known to Respondent during the relevant times.

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6. On December 29, 2014, Patient 1 entered CRCF to begin a seventeen (17) day sentence of incarceration for violating the terms of her furlough from a sentence for petit larceny.

7. Patient 1. was known to Respondent from previous brief incarcerations.

8. Respondent knew that Patient 1 had Type 1 diabetes and that she was inconsistent in complying with her diabetic care.

9. No allegation is being made that Respondent provided inappropriate care to Patient 1 during her prior incarcerations.

10. On December 30, 2014, Patient 1 underwent a "Receiving Screening." The Screening documents revealed that Patient 1 previously had a diagnosis of Diabetes Mellitus and was currently taking two forms of insulin: (1) Lantus and (2) Novolog. Patient 1 reported last taking her insulin on December 28, 2014. Respondent did not participate in the screening and was not at the facility when the screening occurred.

11. At the time of her incarceration, Patient 1 was an active heroin user and appeared disheveled and lethargic. She had a long history of drug abuse and non-compliance with her diabetic care. This resulted in several prior hospitalizations, including a several day stay just prior to her incarceration during which she was treated for diabetic ketoacidosis.

12. During her screening, Patient 1 disclosed her prior hospital stay and that she had pain in her left arm due to a fall she claimed to have suffered while receiving treatment at UVM Medical Center.

13. Upon her admission on December 29, 2014, Patient 1 was placed on a COWS protocol for opiate detox ("Clinical Opiate Withdrawal Scale").

14. On December 30, 2014 Patient 1 refused a full medical history & physical assessment. This was rescheduled for January 4, 2015, and she refused on that day as well.

15. On December 31, 2014, A.D. sustained a fall in her cell, located in the Foxtrot Unit.

16. She reported falling off the bottom bunk and suffering from a stiff neck which appeared to be a result of both her pre-incarceration fall and this fall.

17. She was moved to the infirmary where she remained until January 1, 2015, when she moved back to Foxtrot at approximately 9:00 a.m.

18. While at the infirmary, Patient 1 was irritable and uncooperative.

19. On January 1, 2015, at approximately 2:10 p.m., Patient 1 was moved to the Alpha Unit after she threatened to punch her roommate.

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20. The Alpha Unit is a segregated unit with twenty-four (24) hour video surveillance. Patient 1 remained in the Alpha Unit for the remainder of her incarceration

21. Patient 1 remained on COWS protocol until January 2, 2015. During her three days of detox, she refused assessments by nursing staff as well as her diabetic care. She also made remarks such as "I just want to die". She remained on 15 minute mental health checks during this period of time.

22. On January 2, 2015, Patient 1 was screened by M.L., a licensed clinical social worker. Patient 1 was taken off of the 15 minute mental health checks at this time because she did not have current suicidal ideations. M.L. observed that Patient 1 continued to be uncooperative in her diabetic care.

23. During Patient 1's incarceration at CRCF she had multiple blood glucose readings in the 400s, 500s, and HIGH. She was also inconsistent in compliance with her diabetic care.

24. Beginning on January 3, 2015, and ending on January 6, 2015, Patient 1 exhibited signs of thirst and was at times 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, also document that her mucous membrane was moist and pink, she appeared to be well nourished and hydrated, she was alert and verbally communicative, her radial pulse was equal and strong, and her breathing was even and unlabored.

25. During this same time period, Patient 1 began to appear to have increasing difficulty walking in her cell and getting out of bed. However, she was able to get up to walk around her cell and get her breakfast tray in the morning of January 6th.

26. Respondent was on vacation during the first week of January and did not return to work until the evening of January 4, 2015. She was assigned the "night" (third) shift, which began at 10:00 p.m. and ended at 6:30 a.m. During these evening shifts, only one or two nurses were on duty, and a provider was only available by phone. With only the occasional help of one other nurse, Respondent typically worked the entire evening shift without a break.

27. On January 4, 2015, Respondent received a shift report at the start of her shift, which stated Patient 1 had refused medical care and had indicated that she was "already having symptoms" of high blood sugar.

28. Patient 1 was due to have her diabetic care at approximately 5:30 a.m. on January 5, 2015. At that time, Respondent appeared at the Alpha unit with diabetic supplies in her hand to test Patient 1's blood glucose levels and to administer insulin. Per Vermont Department of Corrections policy, nurses had to be escorted by two Correctional Officers ("CO's") and have the approval of a correctional supervisor in order to be allowed into cells in the Alpha unit during the third shift. Pursuant to that policy, Respondent was escorted by two Correctional Officers ("COs") down the hallway where they stood outside of Patient 1's cell with the door closed.

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Respondent was not permitted into the cell because they were unable to obtain the approval of a correctional supervisor. Respondent told Patient 1 that she was there to test her blood sugar and give her insulin. Patient 1 told her she did not want this care. Respondent and the officers left at that time.

29. As a result of Patient 1's refusal of care, Respondent completed a refusal of care form stating that Patient 1 "refused medication." Respondent checked the worsening of medical conditions box under potential consequences explained by the provider.

30. Respondent was next due to provide diabetic care to Patient 1 on January 6, 2015, at approximately 5:30 a.m. Video confirms that Respondent again appeared at the office of the Alpha unit with diabetic supplies in her hand. The CO in the Alpha office attempted to find another officer to escort Respondent to the cell, but no one was available. The officer was unable to get this approval, so he walked to Patient 1's cell and observed Patient 1 through the food port. He asked Patient 1 if she would accept her diabetic care. Patient 1 refused the care and the officer reported this to Respondent.

31. After Respondent was told by the corrections officer that Patient 1 had refused her diabetic care, Respondent then went to the health center and completed a refusal of care form stating that Patient 1 "refused medication." The refusal of care form documented that Patient 1 "did not want to get up" as the reason for the refusal. In the "potential consequences explained section," Respondent checked the box for worsening of medical conditions.

32. After a provider visit on the morning of January 6, 2015, Patient 1 was placed on the floor of her cell, and later on a mattress on the floor, by COs in an attempt to prevent her from falling off the cot.

33. Respondent arrived for her shift at approximately 10:00 p.m. on January 6, 2015. RN H.A., who had been on duty the previous shift, documented that he made several calls to the on-call provider about Patient 1's high glucose readings and the provider ordered an increase in Novolog, a recheck of Patient 1's blood sugar in two hours, and to call if it was over 400. RN H.A. last administered Novolog to Patient 1 at 10:30 p.m. In reviewing his shift report with Respondent, RN H.A. told Respondent that the on call provider had ordered a re-check of Patient 1's sugar in two hours and to call him if her blood sugar was over 400.

34. When two COs were available to escort Respondent to Patient 1's cell, she and the two officers entered the cell at approximately 1:44 a.m. Respondent documented in a nursing note that at approximately 1:44 she attempted to check Patient 1's blood sugar levels through a finger stick, but Patient 1 refused to speak to her and told Respondent to "get out of [her] cell."

35. Video surveillance on January 7, 2015, shows Respondent entering Patient 1's cell at approximately 1:44 a.m.

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36. Respondent remains by Patient 1's feet while A.D. remains lying on the mattress on the floor.

37. CO M.A. moves towards Patient 1's head and lightly kicks Patient 1's mattress in an attempt to get a response. He eventually leans down toward Patient 1. While the video surveillance has no audio, it appears as though CO M.A. is attempting to speak with Patient 1.

38. Both Respondent and the officers reported that Patient 1 was asked several times if she would accept her diabetic care (her "finger stick") and she refused to answer. CO M.A. asked if she was refusing medical care and Patient 1 told them to "get out of my cell." Respondent and the officers then left the cell. They were in the cell for approximately one minute and ten seconds.

39. The cell video shows that Patient 1 was lying on her mattress on the floor during this attempt to provide care at 1:44 a.m.

40. Respondent did not complete a refusal of care form as a result of her interaction with Patient 1 on January 7, 2015, at approximately 1:44. However, she did document Patient 1 refusal in a nursing note which she completed at 2:02 a.m.

41. Video surveillance also shows that Respondent again attempted to provide diabetic care at approximately 5:48 a.m. on January 7, 2015. Respondent stood in the doorway while two officers entered the cell. For security reasons, CO's sometimes order medical staff to stand near the door, rather than approach an inmate, while they ask an inmate if they will accept care. Respondent asked Patient 1 if she would take her diabetic care but Patient 1 did not answer her. Respondent and the CO's documented that A.D. was breathing deeply. The video shows officers bent over Patient 1 attempting to get a response from her by lightly kicking the mattress and shaking her foot. Respondent again asked her if she wanted diabetic treatment and Patient 1 responded with a distinctive "no." At this time, Patient 1 began to raise her arm with a cupped fist. Respondent documented this attempt in a nursing note, stating that "Pt. started throwing her fist in the air and would not let anyone near her or answer anyone. When asked if pt. wanted diabetic care pt. refused stating 'no'."

42. Video surveillance shows Patient 1 had a cupped or closed fist and she moved her arm a few inches while the officers were in her cell and Respondent was in the doorway. The State contends that the video shows Respondent's description of this movement – that Patient 1 "started throwing her fist in the air and would not let anyone near her"—was not accurate. However, the video was not taken from Respondent's perspective, the cell light was not on and there is no audio. Respondent submits that her description in her nursing note was based on her perception at the time and any inaccuracy was not intended. She prepared her nursing note under time constraints at approximately 5:58 a.m., shortly after Patient 1 refused diabetic care and several hours before Respondent learned that Patient 1 was found unconscious and had been transported to the hospital.

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43. After Respondent's 5:48 a.m. visit to Patient 1, Respondent completed a refusal of care form stating that Patient 1 "refused medication." Respondent checked worsening of medical conditions box under potential consequences explained by the provider.

44. Respondent submits that she did not call the provider because she did not believe Patient 1 was in medical distress and Patient 1 condition did not appear to change during Respondent's shift. Respondent knew that the on-call provider was aware of Patient 1's condition and he did not order a transport to the infirmary or the hospital. Respondent also knew that Patient 1 was scheduled to be seen by a provider in the morning. At the end of her shift at approximately 6:30 a.m. on January 7, 2015, Respondent reviewed her shift report with the next nurse coming on duty. Respondent told her that Patient 1 had refused finger sticks and insulin during the night. She also expressed her concern that Patient 1's refusal to accept care might be "self harm."

45. No medical or correctional staff came to Patient 1's cell until approximately 8:11 a.m. on January 7, 2015. At that time, Patient 1 was found unresponsive on the mattress on her cell floor. Emergency Medical Services responded to CRCF and Patient 1 was taken to UVM Medical Center.

46. Patient 1 died on January 9, 2015. The autopsy report indicates that the cause of death was Diabetes Mellitus.

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.

47. The State re-alleges and incorporates Paragraphs 2 through 46 above.

48. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to engage with patients and to actively encourage them to accept necessary medical care.

49. Respondent failed to meet this standard by engaging in the conduct described above. Specifically, although Respondent did attempt to provide care to Patient 1, she should have done more to encourage Patient 1 to accept her diabetic care and to explain to her the potential consequences of refusing care.

50. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to contribute to the health assessment of an individual, including collecting and reporting data, in order to maintain safe and effective nursing care, and to evaluate the response of the patient to nursing interventions.

51. Respondent failed to meet this standard by engaging in the conduct stated above. Specifically, Respondent should have completed a refusal of care form for Patient 1's

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refusal at 1:44 a.m. on January 7, 2015, and her documentation should have more thoroughly and accurately described what took place when Respondent attempted to provide diabetic care to Patient 1.

52. The essential standards of acceptable and prevailing practice require Licensed Practical Nurses to notify a supervisor or healthcare provider if the nurse is unable to complete care ordered for or needed by the patient.

53. Respondent failed to meet this standard by engaging in the conduct stated above. Specifically, although there was no supervisor on site, in hindsight, Respondent should have called the on-call provider during the evening of January 6-7, 2015, when Patient 1 refused her diabetic care and Respondent was unable to re-check Patient 1's blood sugar as ordered by the provider.

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

Understandings

55. 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 the expense of protracted litigation, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent agrees 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.

56. 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.

57. 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.

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

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

60. 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.

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61. 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.

62. 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 **CONDITIONS** Respondent's license **FOR A MINIMUM OF TWO (2) YEARS**. The conditions will be as follows:

1. Re-issuance of License. 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 in which Respondent works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of fewer 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. In the event Respondent is attending a nursing program which has a clinical portion that involves direct patient care, time spent in direct patient care shall only count toward satisfying the minimum two (2) years of supervised nursing practice if Respondent's nursing program requires an LPN degree. Portions of a nursing program that do not involve direct patient care shall not count toward satisfying the minimum two (2) years of supervised nursing practice.

3. Monitoring. The Office of Professional Regulation, through the Enforcement Case Manager, shall be responsible for monitoring Respondent's compliance with these Conditions. All reports or correspondence regarding compliance with these conditions shall be submitted to the Case Manager in accordance with the Conditions listed below

4. Required Coursework. Respondent must successfully complete (i.e., receive a passing grade, if applicable) the following courses:

   a. Documentation: A Critical Aspect of Client Care, through the National Council of State Boards of Nursing ("NCSBN")
   b. Ethics of Nursing Practice, through NCSBN
   c. Professional accountability & Legal Liability for Nurses, through NCSBN
   d. Righting a Wrong: Ethics & Professionalism in Nursing, through NCSBN
   e. Fundamentals of Diabetes Care, through the American Association of Diabetes Educators

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Respondent must submit written documentation of completion in the form of a certificate of completion and a completed workbook, if applicable, to the Board or its designee. These courses must be completed within one-hundred twenty days (120) days of the date of entry of this Stipulation and Consent Order. Failure to complete these courses within this timeframe shall be a violation of this order.

5. Notification to Employers/Nursing School. 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 submit to the Board an employer agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

   In the event 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, regardless of whether Respondent's time in clinic counts towards satisfying the minimum two (2) years of supervised practice. Respondent shall cause the Program Director to submit to the Board a nursing program agreement form approved by the Board, 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.

6. Reports from Employers/Program Director. Within one (1) month of the date of this order or within one (1) month of the commencement of nursing employment and **monthly** thereafter, Respondent shall cause every nursing employer Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. In the event 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 Respondent's performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

7. Practice Under Supervision. Respondent shall practice as a nurse only in a setting where Respondent has on-sight supervision for the entire shift by a licensed registered nurse or LPN in in a supervisory role that is in good standing with the Board.

8. Types of Employment Prohibited. 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

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private duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

9. Interview with the Board or its Designee. Respondent shall appear in person for interviews with the Board or its designee upon request.

10. 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 or its designee. Respondent must also maintain an active Vermont nursing license for such out-of-state practice to count. The Board will approve out-of-state nursing practice so long as Respondent can still comply with the provisions of this Consent Order. If Respondent receives discipline on a nursing license held in another state during the conditioned period, Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.

11. Notification of Place of Employment/Personal Address/Telephone Number. Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of Respondent's 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 (including resignation or termination), personal address, or telephone number.

12. Notification to Other States. In the event that Respondent is licensed in nursing in any other state(s), Respondent must inform the nursing licensing board of the state(s) in which Respondent is licensed of the conditional status of Respondent's Vermont nursing license within thirty (30) days of the date of entry of this Order.

13. License Renewal. This Order does not automatically extend the license and Respondent must comply with the requirements for license renewal.

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

15. Violation of this Order. If Respondent violates this Order the Board, after giving 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 Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

16. Completion of Conditional License Period or Modification Requests. Respondent shall submit a petition to the Docket Clerk to modify or remove any conditions on Respondent's license. The State will assent to or oppose Respondent's petition. The Board will conduct a hearing if necessary. Respondent bears the burden on any such petition. When requesting removal of conditions, Respondent must present proof that she has fully complied with the terms of this Order and

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Supervised Practice is no longer necessary to protect the public. All conditions remain in full force and effect until such time as the Board modifies this Order.

B. Notwithstanding any provision above, the Respondent must continue to meet all 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: 11/8/17

STATE OF VERMONT
SECRETARY OF STATE

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

Dated: 11/8/17

TARA M. SCHILDHAUER
RESPONDENT

By: _____
Tara M. Schildhauer

APPROVED AS TO FORM ONLY:

Dated: 11/8/17

SANDRA STREMPEL, ESQ.
ATTORNEY FOR RESPONDENT

By: _____
Sandra Strempel, Esq.

APPROVED AND SO ORDERED:

Dated: 11/13/17

VERMONT BOARD OF NURSING

By: _____
Chairperson

Date of Entry: 11/14/17

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