VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

In re	Kathleen Ullmeyer	}
License No.	025-0006008	}
Docket No.	NU 12-0905	}

ENTRY ORDER

The Board of Nursing has reviewed the Stipulation and Consent Order executed by the parties to this contested case and adopted by the Board on today's date; and the Board has also reviewed the evidence related to paragraph 2a on page 4 of the proposed stipulation. In light of the evidence presented by the parties, the Board ORDERS that the Respondent shall work no more than 96 hours during every two week work period during the time Respondent's license conditions are in place.

The Board further ORDERS that the 96 work hour allowance every two week work period shall apply as long as the Respondent remains employed by her current employers, and the Board further ORDERS that the 96 hour work allowance shall apply only to Winooski Family Health Clinic and FAHC University Pediatrics.

Susan O. Farrell

Dated at Montpelier: 10 September 2007

Susan O. Farrell
Vermont State Board of Nursing

Date of Entry: 9/12/07

Date copies sent to:

Resp's Attorney: _____ Prosecuting Attorney: _____

Respondent: _____ Other: _____

Cert. Mail # _____ Docket Clerk's Initials: _____

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

IN RE:	)	
KATHLEEN ULLMEYER	)	**Docket No: NU12-0905**
License No. 025-0006008	)	

STIPULATION AND CONSENT ORDER

NOW COMES the State of Vermont, through State Prosecuting Attorney, Edward G. Adrian, and the Respondent, Kathleen Ullmeyer, L.P.N., 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, 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 ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. The Respondent, Kathleen Ullmeyer, is licensed in the State of Vermont as a licensed practical nurse holding license number 025-0006008. This license was originally issued on or about June 10, 1986 and is currently set to expire on January 31, 2008.

3. At all times relevant, the Respondent was employed as the case manager for the Open Door Clinic (the "Clinic") located in Middlebury, Vermont.

4. By way of history, on or about May 25, 2005, the Respondent was working at the Clinic and became ill. The Respondent left the office that day and subsequently went on emergency medical leave. During the time period that the Respondent was away, other employees at the Clinic assumed the Respondent's duties.

5. In the course of performing the Respondent's duties, employees raised concerns as to certain patient charts:

a. Patient C.C. suffered from lymphoma and was receiving assistance from the Clinic regarding hospice care and end-of-life decisions. C.C. had met with an oncologist at Fletcher Allen Health Care (FAHC) located in Burlington, Vermont on or about April 28, 2005. H.B. requested a record of C.C.'s visit with the oncologist at FAHC which was sent to the Clinic by way of a letter dated April 29, 2005. The Respondent failed to ensure that H.B. was aware of the letter from FAHC. H.B. discovered the letter on the

floor of the Respondent's office on or about May 31, 2005, after the Respondent had gone on medical leave.

b. Patient M.M. had a history of vascular headaches. M.M. was scheduled for an MRI on or about April 26, 2005. The results of the MRI, dated April 27, 2005, were discovered on the Respondent's desk after she left on medical leave. A note in the Respondent's handwriting on the MRI results, dated April 29, 2005, stated "4-29-05 10:20 Pt (patient) aware of nl (normal) results." The Respondent failed to document in M.M.'s chart whether or not the Respondent had reviewed the MRI results with a physician at the Clinic before reporting the results to M.M. The Respondent failed to document in M.M.'s chart that she had reported to M.M. that the MRI results were normal.

c. On or about April 18, 2005, the Respondent provided patient D.M. with a voucher from the Clinic for a urinalysis to be conducted on April 19, 2005. D.M.'s records indicate that D.M. had two urinary tract infections in the previous approximately six (6) months. On the results of D.M.'s urinalysis, the Respondent indicated in a handwritten note, "4-20-05 Pt aware." The Respondent failed to document in D.M.'s chart her conversation with D.M. regarding the specific symptoms that prompted the need for a urinalysis. The Respondent failed to document in D.M.'s chart whether or not the Respondent had consulted with a physician before scheduling the urinalysis for D.M. The Respondent failed to document in D.M.'s chart whether or not she consulted with a physician regarding the results of the urinalysis and an appropriate follow-up plan for D.M.'s care.

d. On or about May 31, 2005, patient S.H. was treated at the Clinic for physical therapy. During her visit, S.H. requested that her blood pressure medication, Atenolol, be refilled. Upon review of S.H.'s records, it was discovered that the last date documented that S.H.'s blood pressure was taken, was December 9, 2003. It was further discovered that the last prescription medication documented for the patient was for Prevacid and entered on January 27, 2004. Finally, the last documented date for which the patient had seen a medical health care provider was May 24, 2004; all other documented visits were for physical therapy. S.H. had apparently been receiving blood pressure medication throughout this time period, although the database entry for S.H. contains no documentation regarding prescription medications and the last entry in S.H.'s chart indicating that she was receiving Atenolol was on January 20, 2004.

S.H.'s file also contained a cytopathology results report for a pap test administered to S.H. on or about May 25, 2004. On the report, dated June 2, 2004, the Respondent indicated in a handwritten note, "7-19-04 Pt aware." The Respondent failed to document in S.H.'s chart whether or not a physician had reviewed the results before the Respondent informed S.H. of the results or whether the Respondent had consulted with a physician regarding follow-up care for S.H.

Charges

6. The acts, omissions and/or circumstances described above, if proven by the State, would constitute grounds for discipline pursuant to:

(i) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Rule IV(II)(B)(1); failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(B)(2);
(ii) 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. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and
(iii) 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

Understandings

7. 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.

8. 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.

9. 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.

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

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

12. 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.

13. 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.

14. 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** the Respondent's license to practice nursing for a period of **ONE (1) YEAR** commencing with the date of entry of this Stipulation and Consent Order. The conditions are as follows:

(1) Re-issue of License.

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

(2) Length of Time 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 **one (1) year** of supervised nursing practice in which she works forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent requests that the Board consider and grant her request that she be permitted to work more than forty (40) hours per week during the conditioned period.

(3) Documentation Course.

Respondent shall complete (i.e., receive a passing grade, if applicable) a course covering the subject of patient documentation, with prior approval by the Board or its designee, and then submit written documentation (certificate of completion, etc.) to verify same to the satisfaction of the Board or its designee. This course must be completed within six (6) months of the date of entry of this Stipulation and Consent Order.

(4) Notification to Employers/Nursing School.

During the conditioned period, 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 commencement of these conditions or of any subsequent nursing employment, Respondent shall cause the Medical Director of the office of Fletcher Allen Health Care University Pediatrics, Jerry Larrabee, M.D., to write to the Board, on the letterhead of Respondent's employer (FAHC), 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 which involves actual patient care, 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 ability of the program to comply with its conditions during clinical experience.

(5) Reports from Employers.

Within one (1) month of the date of entry of this Order, Respondent shall cause every nursing employer Respondent has worked for during the relevant time period to submit to the Board an evaluation of Respondent's performance and attendance during that time period. This report shall be submitted in writing on forms issued by the Board. These reports shall be submitted on a **monthly** basis for the first **six (6) months** of the conditioned period, and on a **bi-monthly** basis thereafter, until such time that the conditions are removed from the Respondent's license.

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.

(6) Practice Under Supervision.

Respondent shall practice only in a nursing setting where Respondent has on-site supervision for the entire shift by a physician or by a registered nurse who is licensed and in good standing with the Board.

(7) Types of Employment Prohibited.

Respondent shall not work as a supervising nurse or for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a personal care provider during the effective period of this Consent Order, unless she petitions the Board and is permitted to engage in such employment.

(8) Out of State Practice/Residence.

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

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

Within five (5) days of the date of entry of this 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.

(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 nursing, 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.

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 full 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:

Dated: 8/13/07

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

KATHLEEN ULLMEYER
RESPONDENT

Dated: 8-8-07

By: _____

APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 8-8-07

By: _____
Ritchie E. Berger, Esq.

APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

Dated: Sept. 10, 2007

By: Susan D. Farrell
Chairperson

Date of Entry: 9/12/07

nu.ullmeyer.stip

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

IN RE:	)	
KATHLEEN ULLMEYER	)	**Docket No: NU12-0905**
License No. 025-0006008	)	

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont and makes the following Charges against the Respondent, Kathleen Ullmeyer, L.P.N.:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands, suspend, revoke, limit, 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 ("ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. The Respondent, Kathleen Ullmeyer, is licensed in the State of Vermont as a licensed practical nurse holding license number 025-0006008. This license was originally issued on or about June 10, 1986 and is currently set to expire on January 31, 2008.

3. At all times relevant, the Respondent was employed as the case manager for the Open Door Clinic (the "Clinic") located in Middlebury, Vermont.

4. By way of history, on or about May 25, 2005, the Respondent was working at the Clinic and became ill. The Respondent left the office that day and subsequently went on emergency medical leave. During the time period that the Respondent was away, other employees at the Clinic assumed the Respondent's duties.

5. In the course of performing the Respondent's duties, employees discovered discrepancies in the following patients' charts:

a. Patient #1 – On or about May 27, 2005 patient M.L. called and left a message at the Clinic advising that she was concerned about the side-effects she was experiencing from her medication. H.B., a physician at the Clinic, was concerned about the patient and attempted to call the patient back. However, H.B. could not find the patient's chart and the Respondent had not yet entered the patient into the Facility's database. The patient had been treated for the first time at the Clinic on or about May 17, 2005. When asked about the patient, the Respondent advised H.B. that the Respondent had already

STATE OF VERMONT

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9 Baldwin Street
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discussed the side-effects of the medication with the patient. The Respondent failed to document this discussion in M.L.'s chart.

b. Patient #2 – Patient C.C. suffered from lymphoma and was receiving assistance from the Clinic regarding hospice care and end-of-life decisions. C.C. had met with an oncologist at Fletcher Allen Health Care (FAHC) located in Burlington, Vermont on or about April 28, 2005. H.B. requested a record of C.C.'s visit with the oncologist at FAHC which was sent to the Clinic by way of a letter dated April 29, 2005. The Respondent failed to ensure that H.B. was aware of the letter from FAHC. H.B. discovered the letter on the floor of the Respondent's office on or about May 31, 2005, after the Respondent had gone on medical leave.

c. Patient #3 – Patient M.M. had a history of vascular headaches. M.M. was scheduled for an MRI on or about April 26, 2005. The results of the MRI, dated April 27, 2005, were discovered on the Respondent's desk after she left on medical leave. A note in the Respondent's handwriting on the MRI results, dated April 29, 2005, stated "4-29-05 10:20 Pt (patient) aware of nl (normal) results." The Respondent failed to document in M.M.'s chart whether or not the Respondent had reviewed the MRI results with a physician at the Clinic before reporting the results to M.M. The Respondent failed to document in M.M.'s chart that she had reported to M.M. that the MRI results were normal.

d. Patient #4 – On or about April 18, 2005, the Respondent provided patient D.M. with a voucher from the Clinic for a urinalysis to be conducted on April 19, 2005. D.M.'s records indicate that D.M. had two urinary tract infections in the previous approximately six (6) months. On the results of D.M.'s urinalysis, the Respondent indicated in a handwritten note, "4-20-05 Pt aware." The Respondent failed to document in D.M.'s chart her conversation with D.M. regarding the specific symptoms that prompted the need for a urinalysis. The Respondent failed to document in D.M.'s chart whether or not the Respondent had consulted with a physician before scheduling the urinalysis for D.M. The Respondent failed to document in D.M.'s chart whether or not she consulted with a physician regarding the results of the urinalysis and an appropriate follow-up plan for D.M.'s care.

e. Patient #5 – On or about May 31, 2005, patient S.H. was treated at the Clinic for physical therapy. During her visit, S.H. requested that her blood pressure medication, Atenolol, be refilled. Upon review of S.H.'s records, it was discovered that the last date documented that S.H.'s blood pressure was taken, was December 9, 2003. It was further discovered that the last prescription medication documented for the patient was for Prevacid and entered on January 27, 2004. Finally, the last documented date for which the patient had seen a medical health care provider was May 24, 2004; all other documented visits were for physical therapy. S.H. had apparently been receiving blood pressure medication throughout this time period, although the database entry for S.H. contains no documentation regarding prescription medications and the last entry in S.H.'s chart indicating that she was receiving Atenolol was on January 20, 2004.

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S.H.'s file also contained a cytopathology results report for a pap test administered to S.H. on or about May 25, 2004. On the report, dated June 2, 2004, the Respondent indicated in a handwritten note, "7-19-04 Pt aware." The Respondent failed to document in S.H.'s chart whether or not a physician had reviewed the results before the Respondent informed S.H. of the results or whether the Respondent had consulted with a physician regarding follow-up care for S.H.

f. Patient #6 – On or about May 14, 2005, the Respondent left H.B. a note requesting that H.B. refill patient R.A.'s prescription for Norvasc. H.B. reviewed R.A.'s chart and left the Respondent a note stating "could we get: SMA-7, fasting profile, LFT's and ask him to come in for a 'touch base visit' BP√? Thanks." R.A.'s file contains documentation that R.A. was asked to come to the clinic or that the Respondent scheduled any of the tests requested by H.B. On or about May 17, 2005, the Respondent presented R.A.'s prescription to another physician to sign, but failed to advise that physician of H.B.'s request.

g. Patient #7 – Patient L.S. was being treated at the Clinic for fibromyalgia, respiratory disease, and hypothyroidism. No information about the patient's prescription medications had been entered in L.S.'s chart or in the Clinic's database since September 21, 2004. After the Respondent left on medical leave, sometime between May 31, 2005 and early June, 2005, H.B. found two prescriptions for L.S. on the floor in the Respondent's office. One prescription was for Flexeril 10mg dated May 3, 2005 and the other prescription was for Levoxyl 150mcg also dated May 3, 2005. Neither of these prescriptions had been entered into the patient's chart or the database.

h. Patient #8 – On or about December 24, 2004, a lab test for occult blood was conducted for patient M.C. The report of the lab results indicated that one of the tests taken had a positive result. The Respondent failed to report M.C.'s lab results to a physician and the Respondent failed to ensure that M.C. received appropriate follow-up care.

Additionally, sometime during the month of June 2005, a volunteer R.N. was cleaning out a traveling cart and discovered an envelope containing a stool guiac card which M.C. had mailed to back to the Clinic. A note on the envelope, which was postmarked December 3, 2004, stated "Neg. X 3." The Respondent failed to document these results in M.C.'s chart or in the Clinic database. There is also no documentation in the patient's chart regarding whether the results had been reported to a physician.

Charges

6. The acts, omissions and/or circumstances described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

(i) 26 V.S.A. § 1582(a)(3) (is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Rule IV(II)(B)(1); failing to conform to the essential standards of

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acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Rule IV(II)(B)(2);

(ii) 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. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

(iii) 3 V.S.A. §129a(a)(3) (failing to comply with the provisions of state statutes or rules governing the practice of the profession).

Relief Requested

WHEREFORE, the license of Kathleen Ullmeyer should be revoked, suspended, reprimanded, conditioned or otherwise disciplined.

DATED at Montpelier, Vermont this 27th day of November 2006.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
Edward G. Adrian
State Prosecuting Attorney

nu.ullmeyer.soc

STATE OF VERMONT

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