VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE:

PAMELA ARRINGTON, L.P.N.

License No.: 0002-066848

<u>ORDER</u>

Pursuant to §§2.2-4020, 54.1-110 and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was held before a panel of the Board of Nursing ("Board") on July 18, 2012, in Henrico County, Virginia, to inquire into evidence that Pamela Arrington, L.P.N., may have violated certain laws and regulations governing practical nursing practice in Virginia. The case was presented by Olivia Exterovich, Adjudication Specialist, Administrative Proceedings Division. Charis A. Mitchell, Assistant Attorney General, was present as legal counsel for the Board. Ms. Arrington was present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Pamela Arrington, L.P.N., was issued License No. 0002-066848 to practice practical nursing by the Virginia Board of Nursing on August 11, 2003. Said license will expire on November 30, 2012. Her primary state of residence is Virginia.

2. On March 28, 2011, during the course of her six-month employment at Riverside Rehabilitation Center-Hampton, Hampton, Virginia, Ms. Arrington failed to initiate CPR on Resident A after being informed that he was unresponsive. After hearing three overhead pages for a supervisor, Cheryl Rudolph, Assistant Director of Nursing, responded to the situation. Ms. Rudolph testified at the formal hearing that when she arrived on the unit, a certified nurse aide was in the room with Resident A and Ms. Arrington and another nurse were in the hall having an argument. Ms. Arrington had already clocked out and

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was arguing with the oncoming day shift nurse about who was responsible for and who should initiate CPR on Resident A.

- 3. Also on March 28, 2011, during the course of her six-month employment at Riverside Rehabilitation Center-Hampton, Ms. Arrington failed to complete blood sugar checks and administer insulin within the time period ordered by the physician for approximately 19 residents. Ms. Anne Moffatt, the Acting Director of Nursing at that time, testified at the formal hearing that she conducted an investigation into the glucometer readings after Resident A expired because the facility was searching for the readings for the resident's most recent test results. During the course of the facility investigation, Ms. Moffat discovered that the readings on the glucometer and the physical documentation in the medical records of the blood sugar tests for numerous residents were disparate. For example:
- a. In the medication administration record for Resident A, Ms. Arrington documented a blood sugar reading of 110 at 0600 hours for Resident A; however, there was no reading in the glucometer to indicate that Ms. Arrington checked Resident A's blood sugar during her shift.
- b. The glucometer indicated that Ms. Arrington checked Resident B's blood sugar at 0339 hours; however, she documented a reading of 173 at 0600 hours. Based on her documentation, Resident B should have received two units of insulin; however, no insulin was administered.
- c. Ms. Arrington documented a reading of 235 at 0600 hours for Resident C and that she administered six units of insulin; however, the only reading on the glucometer was for 0342 hours. She administered the insulin based on a reading that occurred approximately two hours and fifteen minutes prior to administration.
- d. The glucometer indicated that Ms. Arrington checked Resident D's blood sugar at 0401 hours; however, she documented a reading of 180 at 0600 hours. Based on her documentation, Resident D should have received two units of insulin if the reading had occurred at 0600 hours; however, no insulin was administered.

- e. There was no reading in the glucometer to indicate that Ms. Arrington checked Resident E's blood sugar; however, she documented a reading of 150 at 0600 hours.
- f. Resident F was ordered to have his blood sugar checked every six hours. The glucometer indicated that Ms. Arrington checked it at 2349 hours, with a reading of 210, and again at 0257 hours with a reading of 195; however, she documented the reading of 195 at 0600 hours.
- g. There was no reading in the glucometer to indicate that Ms. Arrington checked Resident G's blood sugar; however, she documented a reading of 285 at 0600 hours.
- 4. In the investigative report compiled in the course of the investigation into the glucometer testing, Ms. Moffat stated that Ms. Arrington admitted that the vital signs she had charted for 6:00 a.m. were actually taken at 2:00 a.m. Further, although Ms. Arrington told Ms. Moffat that she did a blood sugar on Resident A at 5:00 a.m., a surveillance video of the entrance to Resident A's room did not show Ms. Arrington entering the room.
- 5. At the formal hearing, Ms. Arrington stated that she had undergone a performance review at 0600 hours on March 28, 2011, the same time that she documented that she had performed the blood sugar checks.
- 6. At approximately 1:30 a.m., on March 28, 2011, Resident A began vomiting. Despite the fact that Resident A had a standing order for Phenergan, Ms. Arrington called her supervisor to receive instruction on how to handle the situation. According to Ms. Arrington's notes for Resident A, she did not give the Phenergan suppository until 4:30 a.m.
- 7. Ms. Arrington has been employed in four different health care positions since receiving her license. She was terminated from two of them for patient care concerns and is ineligible for rehire at a third.
- 8. During the hearing, Ms. Arrington failed to provide credible explanations for her actions and inactions.

CONCLUSIONS OF LAW

- 1. Finding of Fact No. 2 constitutes a violation of §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing ("Regulations").
- 2. Finding of Fact No. 3 constitutes violation of §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(e) and (f) of the Regulations.

ORDER

WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS as follows:

- 1. License No. 0002-066848 issued to Pamela Arrington, L.P.N., to practice practical nursing in the Commonwealth of Virginia is hereby INDEFINITELY SUSPENDED for a period of not less than three years.
- 2. The license privilege of Pamela Arrington, L.P.N., will be recorded as SUSPENDED and no longer current. Should Ms. Arrington seek reinstatement of her license consistent with this Order, she shall be responsible for any fees that may be required for the reinstatement of her license prior to issuance of her license to resume practice.
- 3. At such time as Ms. Arrington shall petition the Board for reinstatement of her license, a hearing will be convened to determine whether she is able to return to the safe and competent practice of practical nursing.
- 4. This Order shall be applicable to Ms. Arrington's multistate licensure privileges, if any, to practice practical nursing in the Commonwealth of Virginia.

Pursuant to §§2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as public record and shall be made available for public inspection or copying on request.

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FOR THE BOARD

Jay P. Douglas, R.N., M.S.M., C.S.A.C.

Executive Director

Virginia Board of Nursing

ENTERED

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.

Certified True Copy

Virginia Board of Nursing