BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **TAMARA JEAN PAULEY, L.P.N.**
License Number: 0002-089307
Case Number: 172786, 172902, and 172943

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Nursing ("Board") held a formal administrative hearing on May 15, 2017, in Henrico County, Virginia, to inquire into evidence that Tamara Jean Pauley, L.P.N. may have violated certain laws and regulations governing the practice of practical nursing in the Commonwealth of Virginia.

Tamara Jean Pauley, L.P.N., did not appear at this proceeding and was not represented by legal counsel.

NOTICE

By letter dated March 3, 2017, the Board sent a Notice of Formal Hearing ("Notice") to Ms. Pauley notifying her that a formal administrative hearing would be held on March 23, 2017. The Notice was sent by certified and first class mail to the legal address of record on file with the Board. By letter dated April 19, 2017, the Board sent an Amended Notice of Formal Hearing to Ms. Pauley notifying her that a formal administrative hearing would be held on May 15, 2017. The Amended Notice was set by certified and first class mail to the legal address of record on file with the Board. According to the USPS tracking website, notice was left at Ms. Pauley's address of record for the Notice sent by certified mail on March 6, 2017. The Notice sent by first class mail was not returned to the Board office. According to the USPS tracking website, the Amended Notice was delivered on April 22, 2017.

The Amended Notice sent by first class mail was not returned to the Board office. Accordingly, the panel Chair concluded that adequate notice was provided to Ms. Pauley and the formal hearing proceeded in her absence.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT

1. Tamara Jean Pauley, L.P.N., was issued License Number 0002-089307 to practice practical nursing on July 15, 2013. Said license is scheduled to expire on July 31, 2017. At all times relevant to the findings contained herein, said license was current and active. Her primary state of residence is Virginia.

2. During the course of her assignment with Pheasant Ridge Nursing and Rehabilitation Center, Roanoke, Virginia, through her employer Maxim Healthcare, on February 25, 2016, Ms. Pauley diverted oxycodone (C-II) and diazepam (C-IV) for her own personal and unauthorized use, as evidenced by the following:

a. On three occasions, at 11:00 a.m., 5:00 p.m., and 9:00 p.m., Ms. Pauley removed two 10mg oxycodone tablets for Patient A, who was prescribed one 10mg oxycodone tablet every six hours, as needed. In addition, she documented the administration of the medication but did not document the time of administration.

b. Ms. Pauley documented withdrawing diazepam 2mg at 8:00 p.m. for Patient B, who was prescribed one 2mg tablet three times a day as needed, and documented the administration of the medication, but did not document the time of administration. The nurse who relieved Ms. Pauley noted that Patient B, with whom she was very familiar, was awake all night, and that Patient B would normally sleep following the administration of diazepam.

3. As a result of these incidents, Pheasant Ridge Nursing and Rehabilitation Center terminated Ms. Pauley's contract with the facility.

4. Based on these incidents, Maxim Healthcare asked Ms. Pauley to report for a mandatory drug screening on March 26, 2016. Ms. Pauley failed to report for the drug screening, and her employment with Maxim Healthcare was terminated effective April 1, 2016 for failure to adhere to Maxim Healthcare's substance abuse policy.

5. During the course of her employment with Friendship Health and Rehabilitation Center, Roanoke, Virginia, between February 8 and March 7, 2016, Ms. Pauley diverted oxycodone, hydrocodone (C-II), and fentanyl (C-II) for her own personal and unauthorized use, as evidenced by the following:

a. On February 15, 2016, at 4:00 p.m., Ms. Pauley documented the removal of two tablets of oxycodone 5mg for Patient C, who was prescribed one tablet oxycodone 5mg every six hours, as needed for pain. Ms. Pauley documented the witnessed waste of one tablet. However, Ms. Pauley failed to document the administration, waste, or return of the remaining tablet of oxycodone 5mg.

b. On February 26, 2016, Ms. Pauley documented in the MAR the application of a fentanyl patch 25mcg/hr to Patient D, who was prescribed one new 25mcg/hr patch every 72 hours. Ms. Pauley failed to document the withdrawal of the fentanyl patch on the Narcotic Count Sheet. Patient D reported that her fentanyl patch had not been replaced by Ms. Pauley. The oncoming nurse examined the existing patch, which was dated February 23, 2016 and initialed by a nurse other than Ms. Pauley.

c. On February 28, 2016, Ms. Pauley documented the withdrawal and waste of two tablets of oxycodone 5mg without specifying the time of the withdrawal, and without a witness to the waste, for Patient D, who was prescribed two tablets every four hours as needed.

d. On February 18, 2016 at 10:00 p.m., Ms. Pauley documented the withdrawal and administration of one tablet of hydrocodone 10mg for Patient E, who was prescribed one tablet every four hours. Patient E reported to the oncoming nurse that she had not received her pain medication.

e. On February 28, 2016, Ms. Pauley administered doses of 0.25ml oxycodone early, at 6:40 p.m. and 9:49 p.m., to Patient F, who was prescribed 0.25ml oxycodone every six hours and every four hours as needed.

f. On February 18, 2016, at 10:00 p.m., Ms. Pauley documented the administration of one tablet of hydrocodone 5mg to Patient G, who was prescribed one tablet three times a day. Patient G reported never receiving the hydrocodone.

6. Ms. Pauley quit her position with Friendship Health and Rehabilitation Center without notice by voicemail on March 7, 2016.

7. During the course of her assignment with Virginia Veterans Care Center, Roanoke, Virginia, through her employer NurseSpring, Roanoke, Virginia, between March 1 and March 3, 2016, Ms. Pauley diverted oxycodone, morphine (C-II) and fentanyl (C-II) for her own personal and unauthorized use, as evidenced by the following:

a. On March 1, 2016 at 9:00 a.m., Ms. Pauley documented the withdrawal of one tablet of morphine 30mg for Patient H, who was prescribed one 30mg tablet every twelve hours at 9:00 a.m. and 9:00 p.m. Ms. Pauley was not scheduled to work on March 1, 2016, and she failed to document administration, return, or waste of the tablet.

b. On March 2, 2016 at 5:00 p.m., Ms. Pauley documented the removal and application of a fentanyl patch 25mcg/hr for Patient H, who was prescribed one patch every three days. However, the nurse on the next shift could not locate the patch, and another was ordered and administered.

c. On March 1, 2016 at 3:00 p.m., Ms. Pauley documented the withdrawal of one tablet of oxycodone 5mg for Patient I, who was prescribed one tablet every four hours, as needed. Ms. Pauley was not scheduled to work on March 1, 2016, and she failed to document administration, return, or waste of the tablet.

d. On March 2, 2016 and March 3, 2016 between approximately 3:00 p.m. and 7:00 a.m., Ms. Pauley documented the withdrawal of seven tablets of oxycodone 5mg for Patient I and documented administration of two tablets. She failed to document administration, return, or waste of the remaining five tablets.

e. On March 3, 2016 at 5:30 a.m., Ms. Pauley documented three separate withdrawals of two tablets (six total) of oxycodone 5mg for Patient J, who was prescribed two tablets every four hours, as needed. She documented wasting all six tablets.

f. On March 3, 2016 at 7:00 a.m., Ms. Pauley documented the withdrawal of two tablets of oxycodone 5mg for Patient J, and failed to document any administration, return, or waste of the tablets.

8. As a result of these incidents, Ms. Pauley's contract with Virginia Veterans Care Center was terminated.

9. As a result of these incidents, NurseSpring requested that Ms. Pauley submit to a drug test on March 3, 2016. Ms. Pauley refused, and as a result, her employment was terminated effective March 3, 2016 for violating NurseSpring's substance abuse policy.

10. By her own admission, during the course of her employment as a private duty nurse in Bedford County, Virginia, between November 2015 and December 2015, Ms. Pauley diverted narcotic medications from the supply of Patient K.

11. On December 13, 2015, Ms. Pauley received emergency treatment for opiate withdrawal at Centra Lynchburg General Hospital, Lynchburg, Virginia. Her admission diagnoses included panic disorder and opioid use, unspecified with withdrawal.

12. On March 31, 2016, Ms. Pauley told an investigator for the Department of Health Professions that her December 13, 2015 hospitalization was a result of her overdosing on the medication she had diverted from Patient K.

13. On February 1, 2016, Ms. Pauley's treatment provider at Carilion Clinic, Bedford, Virginia, wrote that she would no longer prescribe narcotics to Ms. Pauley because Ms. Pauley had shown "clear signs of addiction and abuse of these medications."

14. Beginning in July 2015, Ms. Pauley received treatment from Medical Associates of Central Virginia, Lynchburg, Virginia, for bipolar disorder, anxiety, and depression.

15. On April 11, 2017 in the Circuit Court for the County of Bedford, Virginia, Ms. Pauley was convicted of one count of petit larceny and received a deferred disposition for one count of felony possession of a controlled substance. These charges were both the result of her diversion from Patient K.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 2(a) and 2(b) constitute a violation of Virginia Code § 54.1-3007(2), (5), and (8) and 18 VAC 90-20-300(A)(2)(c), (e), and (f) of the Regulations Governing the Practice of Nursing ("Regulations") (currently found at 18 VAC 90-19-230(A)(2)(c), (e), and (f), effective February 24, 2017).

2. Findings of Fact Nos. 5(a) through 5(f) constitute a violation of Virginia Code § 54.1-3007(2), (5), and (8) and 18 VAC 90-20-300(A)(2)(c), (e), and (f) of the Regulations (currently found at 18 VAC 90-19-230(A)(2)(c), (e), and (f), effective February 24, 2017).

3. Findings of Fact Nos. 7(a) through 7(f) constitute a violation of Virginia Code § 54.1-3007(2), (5), and (8) and 18 VAC 90-20-300(A)(2)(c), (e), and (f) of the Regulations (currently found at 18 VAC 90-19-230(A)(2)(c), (e), and (f), effective February 24, 2017).

4. Finding of Fact No. 10 constitutes a violation of Virginia Code § 54.1-3007(2), (5), (6), and (8) and 18 VAC 90-20-300(A)(2)(c) and (f) of the Regulations (currently found at 18 VAC 90-19-230(A)(2)(c) and (f), effective February 24, 2017).

5. Findings of Fact Nos. 11 through 13 constitute a violation of Virginia Code § 54.1-3007(6).

6. Pursuant to Virginia Code § 54.1-2400.2(K), the Board considered whether to disclose or not disclose Ms. Pauley's health records or health services.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Nursing hereby ORDERS as follows:

1. The license issued to Tamara Jean Pauley, L.P.N., to practice practical nursing in the Commonwealth of Virginia is INDEFINITELY SUSPENDED for a period of not less than two years from the date of entry of this Order.

2. The license of Tamara Jean Pauley, L.P.N., will be recorded as SUSPENDED.

3. This suspension applies to any multistate privilege to practice practical nursing.

4. Should Ms. Pauley seek reinstatement of her license, an administrative proceeding shall be convened to consider such application. At such time, the burden shall be on Ms. Pauley to

demonstrate that she is safe and competent to return to the practice of practical nursing. Ms. Pauley shall be responsible for any fees that may be required for the reinstatement and/or renewal of the license prior to issuance of the license to resume practice.

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

FOR THE BOARD

Jay Douglas, M.S.M., R.N., C.S.A.C., F.R.E.
Executive Director
Virginia Board of Nursing

ENTERED AND MAILED ON:

May 26, 2017

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 Douglas, M.S.M., R.N., C.S.A.C., F.R.E., 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
By dgraham
Virginia Board Of Nursing