BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **KRYSTINA AGNES LOPRETE, R.N.**
License Number: 0001-254481
Case Number: 170656

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Nursing ("Board") held an informal conference on August 1, 2016, in Henrico County, Virginia, to inquire into evidence that Krystina Agnes Loprete, R.N., may have violated certain laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

Krystina Agnes Loprete, R.N. appeared at this proceeding and was not represented by legal counsel.

NOTICE

By letter dated July 5, 2016, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Loprete notifying her that an informal conference would be held on August 1, 2016. The Notice was sent by certified and first class mail to the legal address of record on file with the Board of Nursing. By letter dated July 28, 2016, the Board of Nursing hand-delivered an Amended Notice to Ms. Loprete on August 1, 2016.

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Krystina Agnes Loprete, R.N. was issued License Number 0001-254481 to practice professional nursing on September 19, 2014, which is scheduled to expire on August 31, 2018. At all times relevant to the findings contained herein, said license was in full force and effect. Her primary state of residence is Virginia.

2. Ms. Loprete violated Virginia Code § 54.1-3007(2), (5), and (8) and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing in that during the course of her employment with Sentara Norfolk General Hospital, Norfolk, Virginia ("SNGH"):

a. Ms. Loprete failed to perform assessments on each patient assigned to her. For example, on September 30, 2015 Ms. Loprete failed to assess and coordinate the care of Patient A. At the informal conference, Ms. Loprete stated that Patient A refused her assessment and care, but offered no corroborating evidence of Patient A's refusal.

b. By her own admission, Ms. Loprete bypassed the bar scanning safety system designed to prevent medication administration errors and failed to document the administration of medications to her patients. For example, on September 29, 2015, Ms. Loprete administered ordered IV meropenem to Patient B. However, Ms. Loprete failed to scan the medication or the patient before administering the IV. At the informal conference Ms. Loprete stated that she now realizes the importance of scanning each medication prior to its administration.

c. By her own admission, on October 1, 2015, Ms. Loprete failed to start the administration of Xarelto (rivaroxaban) to Patient A at 0100 hours as ordered. Instead, Ms. Loprete administered the medication at 0731 hours. Ms. Loprete explained at the informal conference that the physician's orders had been changed to reflect a Xarelto administration start time at 0900 hours on

October 1, 2016, however, she failed to document the change. Ms. Loprete stated that she was working to improve her documentation issues.

d. By her own admission, Ms. Loprete failed to administer ordered Florastor (Saccharomyces boulardii) 250 mg PO TID and ascorbic acid 500mg PO BID to Patient C as ordered. On September 27 and 29, 2016, Ms. Loprete noted in Patient C's medication administration record that the ascorbic acid was "held" because Patient C "cannot swallow." On September 29, 2015 Ms. Loprete documented that the Florastor was "held" because "pt. is npo." Ms. Loprete was instructed by the charge nurse to reschedule Patient C's medication administration, but she failed to do so. On September 30, 2015, at 0047 hours, Ms. Loprete documented that Patient C's orders were changed to reflect that the medications could be administered by NG-Tube. Despite the change, Ms. Loprete again failed to administer the medications. At the informal conference, Ms. Loprete explained that she withheld the medication because she could not contact the physician about the change in orders. However, Ms. Loprete admitted that she should have consulted the supervising nurse to facilitate the process.

e. On July 28, 2015, Ms. Loprete permitted a patient to leave the hospital unit when it was unsafe for him to do so. In addition, Ms. Loprete failed to notify the patient's physician until after the patient eloped a second time. At the informal conference Ms. Loprete admitted that while she did not notify the physician, she informed security, patient care services and the patient's family. Ms. Loprete stated that she realizes now the importance of notifying the physician when patient issues arise.

3. Ms. Loprete violated Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(e) and (f) of the Regulations in that, during the course of her employment with SNGH, by

her own admission, she did not use a stethoscope consistently in the performance of her assessments despite documenting breath sounds in patient records with specificity. For example:

a. On September 30, 2015 at 0000 hours, Ms. Loprete documented in Patient B's flowsheet data report that he had "coarse and diminished" breath sounds, terms difficult to confirm without the use of a stethoscope. During an investigation conducted by SNGH, Patient B denied that Ms. Loprete had ever listened to his breathing. At the informal conference, Ms. Loprete stated that she always used a stethoscope during initial assessments, but did not consistently do so during "focused" or system-based assessments. Ms. Loprete agreed that a stethoscope should be used in all assessments.

b. On September 29, 2015 at 2011 hours, Ms. Loprete documented in Patient D's flowsheet data report that his breath sounds were "equal bilaterally". Ms. Loprete admitted that she did not touch Patient C, but stated that she did listen to his lungs using a stethoscope. During an investigation conducted by SNGH, Patient D stated that Ms. Loprete did not touch him and only gave him medications. Patient D denied that Ms. Loprete listened to his chest. At the informal conference, Ms. Loprete stated she did listen to the patient's breathing with a stethoscope. She had no explanation as to why the patient would report that she did not.

4. Ms. Loprete violated Virginia Code § 54.1-3007(2) and 18 VAC 90-20-300(A)(2)(e) of the Regulations in that during the course of her employment with SNGH, she documented in Patient A's medical record that Patient A declined her medication because the hanging IV bag would make her room feel smaller. Patient A denied refusing any part of her care. During an investigation conducted by SNGH, Patient A stated that Ms. Loprete performed no assessment upon her admission to the unit and that Ms. Loprete informed her that her IV and medications would be started on the next shift. At the informal conference, Ms. Loprete stated that she advocated for a larger room for her patient, but admitted that she failed to fully document her interventions and actions in the patient record.

5. Ms. Loprete's employment with SNGH was terminated on October 9, 2015.

6. Ms. Loprete stated at the informal conference that she is currently employed as a travel nurse with Professional Placement Resources, Jacksonville Beach, Florida ("PPR") and placed at Bon Secours, Maryview, where she has been for 2.5 months. Ms. Loprete stated that Maryview was aware of her appearance before the Committee but PPR was not.

7. Ms. Loprete stated that she hopes to obtain a permanent position with Maryview.

8. Ms. Loprete submitted several letters of recommendation that spoke to her clinical competency for consideration by the Committee.

ORDER

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

1. Krystina Agnes Loprete is REPRIMANDED.

2. Within 90 days from the date of entry of this Order, Krystina Agnes Loprete shall provide written proof satisfactory to the Board of successful completion of the following NCSBN courses:

   a. Professional Accountability & Legal Liability for Nurses; and

   b. Documentation: A Critical Aspect of Client Care.

3. Krystina Agnes Loprete shall comply with all laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

4. Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of professional nursing shall constitute grounds for further disciplinary action.

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:
August 12th, 2016

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Ms. Loprete may, not later than 5:00 p.m., on September 14, 2016, notify Jay Douglas, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on September 14, 2016, unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By
Virginia Board of Nursing