BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **GARY CHARLES LEAUBY, JR., R.N.**
License Number: **0001-238086**
Issue Date: **June 20, 2012**
Expiration Date: **August 31, 2016**
Case Number: **172579**

NOTICE OF INFORMAL CONFERENCE AND STATEMENT OF ALLEGATIONS

You are hereby notified that an Informal Conference has been scheduled before the Board of Nursing ("Board") regarding your license to practice professional nursing in the Commonwealth of Virginia.

TYPE OF PROCEEDING:	This is an informal conference before a Special Conference Committee of the Board of Nursing.
DATE AND TIME:	**August 1, 2016** **9:00 A.M.**
PLACE:	Virginia Department of Health Professions Perimeter Center - 9960 Mayland Drive 2nd Floor - Virginia Conference Center Henrico, Virginia 23233

LEGAL AUTHORITY AND JURISDICTION:

1. This informal conference is being held pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10). This proceeding will be convened as a public meeting pursuant to Virginia Code § 2.2-3700.

2. At the conclusion of the proceeding, the Committee is authorized to take any of the following actions:

- Exonerate you;
- Reprimand you;
- Require you to pay a monetary penalty;
- Place you on probation and/or under terms and conditions;
- Refer the matter to the Board of Nursing for a formal administrative hearing;
- Offer you a consent order for suspension or revocation of your license in lieu of a formal hearing.

ABSENCE OF RESPONDENT AND RESPONDENT'S COUNSEL:

If you fail to appear at the informal conference, the Committee may proceed to hear this matter in your absence and may take any of the actions outlined above.

RESPONDENT'S LEGAL RIGHTS:

You have the right to the information on which the Committee will rely in making its decision, to be represented by counsel at this proceeding, to subpoena witnesses and/or documents, and to present relevant evidence on your behalf.

COMMONWEALTH'S EXHIBIT:

Enclosed is a copy of the documents that will be distributed to the members of the Committee and will be considered by the Committee when discussing any allegations with you and when deliberating on your case. **These documents are enclosed only with the notice sent by certified mail, which you may be required to claim at the post office. Please bring these documents with you to the informal conference.**

FILING DEADLINES:

1. Deadline for filing exhibits: **July 25, 2016.** Submit 7 copies of all documents you want the Board to consider to Sylvia Tamayo-Suijk, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. Exhibits may not be sent by facsimile or e-mail.

2. Deadline for filing motions, including motions for continuance or objections to exhibits, in writing, to Sylvia Tamayo-Suijk at the above address: **July 25, 2016**. NOTE: Failure to object to the distribution prior to the proceeding will not affect your right to contest any information contained in these documents at the proceeding.

STATEMENT OF ALLEGATIONS

The Board of Nursing alleges that:

1. At all times relevant hereto, Gary Charles Leauby, Jr., R.N. was licensed to practice professional nursing in the Commonwealth of Virginia.

2. Gary Charles Leauby, Jr., R.N. violated Virginia Code § 54.1-3007(2) and (5) and 18 VAC 90-20-300(A)(2)(e) of the Regulations Governing the Practice of Nursing in that, during the course of his employment with Bon Secours St. Mary's Hospital, Richmond, Virginia ("SMH"):

a. On or about February 29, 2015, Mr. Leauby added saline to a fentanyl (C-II) syringe that had originally contained 100 mcg of fentanyl. Mr. Leauby administered the diluted fentanyl to Patient A. Mr. Leauby falsely documented in Pyxis, Patient A's medication administration record ("MAR") and Patient A's procedure report that a full dose of fentanyl was given as ordered. Mr. Leauby failed to report the incident to his supervisor.

b. On or about June 30, 2015, Mr. Leauby administered 400 mg of Neo-Synephrine (phenylephrine) to a critical patient instead of the ordered 100 mg. Mr. Leauby failed to clarify the order with the physician, failed to scan the dose in the patient's MAR and failed to report the error to his supervisor.

c. On or about February 21, 2014, Mr. Leauby mislabeled a urine specimen collected from a patient. Mr. Leauby failed to identify the patient by examining the patient's wrist band and failed to verify the name on the specimen label.

See Confidential Attachment I for the name of the patient referenced above.

RD, MS

Gloria Mitchell-Lively, R.N., M.S.N., M.B.A.
Deputy Executive Director
Virginia Board of Nursing

July 5, 2016
Date