BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **CARMEN CASSANDRA GOMEZ BORGES, R.N.**
License Number: 0001-191588
Case Number: 160210, 162046

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 July 20, 2016, in Henrico County, Virginia, to inquire into evidence that Carmen Cassandra Gomes Borges, R.N., may have violated certain laws and regulations governing the practice of professional nursing in the Commonwealth of Virginia.

Carmen Cassandra Gomez Borges, R.N. did not appear at this proceeding and was not represented by legal counsel.

NOTICE

By letter dated June 24, 2016, the Board of Nursing sent a Notice of Formal Hearing ("Notice") to Ms. Borges notifying her that a formal administrative hearing would be held on July 20, 2016. The Notice was sent by certified and first class mail to the legal address of record on file with the Board of Nursing. The Notice sent by certified mail to the address of record was accepted on June 24, 2016. As of July 20, 2016, the 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. Borges 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. On July 21, 2004, the Board of Nursing issued License Number 0001-191588 to Carmen Cassandra Gomez Borges, R.N. to practice professional nursing in the Commonwealth of Virginia. Said license is scheduled to expire on August 31, 2017. At all times relevant hereto, said license was in full force and effect. Her primary state of residence is Virginia.

2. Ms. Borges' license was summarily suspended by Order of the Board entered on February 2, 2007. By Order of the Board entered March 9, 2007 ("Board's Order") Ms. Borges's license was indefinitely suspended as a result of her admitted dependence on narcotic medication and diversion of narcotics from her employer. By Board's Order entered December 20, 2010, Ms. Borges' license was reinstated contingent upon her entry into and compliance with the Health Practitioners' Monitoring Program.

3. Term Number 1 of the Board's Order entered December 20, 2010, required her to comply with the terms and conditions of the Health Practitioners' Monitoring Program ("HPMP"). On October 15, 2014, she was urgently dismissed from the HPMP for noncompliance with her Recovery Monitoring Contract. Specifically, she returned to practice without notifying the HPMP.

4. Between July 25, 2014, and October 8, 2014, during the course of her employment with University of Virginia Health Service, Charlottesville, Virginia, Ms. Borges diverted hydromorphone (Dilaudid, C-II) for her own personal and unauthorized use, as evidenced by the following:

a. On July 25, 2014, at 0757 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient A, who was not her assigned patient. She documented that the medication was cancelled, but at 2052, she wasted 19.2mg, leaving .8mg unaccounted for.

b. On July 28, 2014, at 0719 she removed a hydromorphone 20mg/100ml cassette for Patient A, and documented that she canceled the medication at 0719. She documented that she

wasted 17.6cc at 1146 and 1mg at 2000. She failed to document administration of the medication to Patient A.

c. On July 29, 2014, at 0944 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient B, who was not her assigned patient. She noted on the Medication Administration Record that the dosage was cancelled. At 1345 she wasted 20mg of hydromorphone, approximately four hours after she removed the cassette at 0944.

d. On July 30, 2014, at 0745 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient B, but failed to document whether she administered, wasted or returned the medication. At 1857 she documented that she wasted 1mg of hydromorphone and at 2010 she documented that she wasted 20mg of hydromorphone.

e. On August 2, 2014, at 0744 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient C. She failed to document whether the medication was administered, wasted or returned. At 1225 she removed another cassette for Patient C and documented that she wasted 1.2mg. At 1856 she removed a hydromorphone 20mg/100ml cassette from the Pyxis, but failed to document whether she administered, wasted or returned that cassette.

f. On August 3, 2014, at 1311 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient C, but failed to document if the medication was administered, wasted or returned.

g. On August 4, 2014, at 1842 she withdrew a hydromorphone 20mg/100ml cassette from the Pyxis for Patient D, who not her assigned patient. She failed to document whether the cassette was administered, wasted or returned to the Pyxis. At 1934 she documented that she wasted 1mg of hydromorphone, which left 19mg unaccounted for.

h. On August 4, 2014, at 0400 Patient E had 51cc of hydromorphone remaining in her cassette. At 0733 Ms. Borges withdrew a hydromorphone 20mg/100ml cassette from the Pyxis for Patient E, but failed to document whether the medication was administered, wasted or returned.

i. On October 5, 2014, at 0800 she removed a hydromorphone 20mg/100ml cassette from the Pyxis for Patient F. Patient F, who was alert and oriented, denied that Ms. Borges replaced her cassette, and reported to staff that she observed Ms. Borges removing medication from her cassette using an empty syringe.

j. On October 8, 2014, Patient G was ordered to receive .5mg of hydromorphone every three hours as needed. At 0745 Ms. Borges removed a hydromorphone 2mg cassette from the Pyxis for Patient G, and documented wasting 1.5mg at 0750. At 0939, approximately one hour early for the patient's next dose, she removed another hydromorphone 2mg for Patient G, and documented that she wasted 1.5mg at 1050. Further, she did not document administration until an hour after removing the medication. At 1139, again an hour early for Patient G's scheduled dosage, she removed hydromorphone 2mg and documented that the medication was canceled, and that she wasted 1.5mg, which left .5mg unaccounted for.

5. Between January 27, 2015, and February 19, 2015, during the course of her employment as a contract nurse with Virginia Commonwealth Health Systems, Richmond, Virginia, through At Home Care, Richmond, Virginia, she diverted hydromorphone (Dilaudid, C-II) for her own personal and unauthorized use, as evidenced by the following:

a. On January 27, 2015, at 0759 she removed hydromorphone 2mg from the Pyxis for Patient H, but wasted 1mg at 0949 and 1mg at 1056. At 0919 she removed hydromorphone 2mg from the Pyxis and documented that she administered 1mg at 0925, but failed to waste the remaining

1mg until 1029. At 1556 she removed hydromorphone 2mg from the Pyxis for Patient H, and administered 1mg, but failed to document wastage of the remaining 1mg.

b. On January 28, 2015, at 0741 she removed hydromorphone 2mg from the Pyxis for Patient H, but did not administer the medication. She wasted 2mg at 1015, over two hours after removing the medication.

c. On February 5, 2015, at 0726 she removed hydromorphone 2mg for Patient H, but did not administer the medication. She wasted 1mg at 1301, approximately four hours after removal, and at 1708 she wasted 1mg, approximately nine hours after removal of the medication. At 1121 she removed hydromorphone 2mg, and documented administration at 1136, but did not waste the remaining 1mg until 2007, approximately eight hours after removal of the medication.

d. On January 31, 2015, at 0745 she removed hydromorphone 2mg from the Pyxis for Patient I, but did not administer the medication. At 1138, she wasted 1mg and at 1224 she wasted the remaining 1mg of the medication. At 1242 she removed hydromorphone 2mg, but did not administer the medication. At 1651 she wasted the medication, approximately four hours after removing it from the Pyxis.

e. On February 5, 2015, at 0900 she removed hydromorphone 2mg from the Pyxis for Patient J, but failed to document whether the medication was administered, wasted or returned.

f. On February 10, 2015, at 0732 she removed hydromorphone 2mg from the Pyxis for Patient J, but did not administer the medication. At 1315, approximately five hours after removal, she wasted the medication. At 0827, she removed hydromorphone 2mg, but did not administer the medication. At 1440, approximately six hours after removal, she wasted the 2mg.

g. On February 11, 2015, at 0722 she removed hydromorphone 2mg, and documented that she wasted 1.5mg at 1517, approximately eight hours after removal, leaving .5mg

unaccounted for. At 1445 she removed hydromorphone 2mg, but did not administer the medication to Patient J. At 1716, approximately two hours after removal, she wasted all of the medication.

h. On February 11, 2015, at 1725 she removed hydromorphone 2mg from the Pyxis for Patient K, but did not administer the medication. She wasted the medication at 2103, approximately two hours after removing the medication.

i. On February 18, 2015, at 0913, she removed hydromorphone 2mg for Patient K, but did not administer the medication. At 1303, approximately four hours after removal, she wasted all of the medication. At 1234 she removed hydromorphone 2mg, but did not administer the medication to Patient K. At 1526, approximately three hours after removal, she wasted all of the medication.

j. On February 19, 2015, at 0958 she removed hydromorphone 2mg from the Pyxis for Patient K. She failed to document if she administered, wasted or returned the medication. At 1639 she removed hydromorphone 2mg from the Pyxis for Patient K, but did not document administration of the medication. At 1732, she wasted 1mg, which left 1mg unaccounted for.

k. On February 15, 2015, at 1558 she removed hydromorphone 2mg from the Pyxis for Patient L, but did not administer the medication. At 1659 she documented wasting the 2mg, approximately one hour after she removed the medication.

CONCLUSIONS OF LAW

1. Finding of Fact No. 3 constitutes a violation of Virginia Code § 54.1-3007(6) and Term Number 1 of the Board's Order entered December 20, 2010.

2. Findings of Fact Nos. 4(a) – 4(j) constitute a violation of Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations Governing the Practice of Nursing ("Regulations").

3. Findings of Fact Nos. 5(a) – 5(k) constitute a violation of Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations..

ORDER

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

1. Carmen Cassandra Gomez Borges is REPRIMANDED.

2. The license issued to Ms. Borges to practice professional 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.

3. The license of Ms. Borges will be recorded as SUSPENDED.

4. This suspension applies to any multistate privilege to practice professional nursing.

5. Should Ms. Borges seek reinstatement of her license, an administrative proceeding shall be convened to consider such application. At such time, the burden shall be on Ms. Borges to demonstrate that she is safe and competent to return to the practice of professional nursing. Ms. Borges 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

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

ENTERED AND MAILED ON:
August 5th, 2016

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