BEFORE THE VIRGINIA BOARD OF NURSING

IN RE: **CARMEN CASSANDRA GOMEZ BORGES, R.N.**
License Number: **0001-191588**
Issue Date: **July 21, 2004**
Expiration Date: **August 31, 2017**
Case Number: **160210 and 162046**

NOTICE OF FORMAL ADMINISTRATIVE HEARING AND STATEMENT OF ALLEGATIONS

You are hereby notified that a Formal Hearing 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 a formal administrative hearing before a panel of the Board of Nursing.
DATE AND TIME:	**July 20, 2016** **1:00 P.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 formal hearing is being held pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11). This proceeding will be convened as a public meeting pursuant to Virginia Code § 2.2-3700.

2. At the conclusion of the proceeding, the Board 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;
- Suspend your license;
- Revoke your license.

ABSENCE OF RESPONDENT AND RESPONDENT'S COUNSEL:

If you fail to appear at the formal hearing, the Board 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 Board 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 Board and will be considered by the Board 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 formal hearing.**

FILING DEADLINES:

1. Deadline for filing exhibits: **July 5, 2016.** Submit 15 copies of all documents you want the Board to consider to Darlene Graham, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. Exhibits may not be sent by facsimile or e-mail. Please note that any documentation or evidence that you previously submitted for an informal conference must be resubmitted for consideration by the Board at the formal hearing.

2. Deadline for filing motions, including motions for continuance or objections to exhibits, in writing, to Darlene Graham at the above address: **July 5, 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, Carmen Cassandra Gomez Borges, R.N. was licensed to practice professional nursing in the Commonwealth of Virginia.

2. Carmen Cassandra Gomez Borges, R.N. violated Virginia Code § 54.1-3007(6) and Term Number 1 of the Board's Order entered December 20, 2010, which required her to comply with the terms and conditions of the Health Practitioners' Monitoring Program ("HPMP"), in that 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.

3. Ms. Borges violated 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") in that between July 25, 2014, and October 8, 2014, during the course of her employment with University of Virginia Health Service, Charlottesville, Virginia, she 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.

4. Ms. Borges violated Virginia Code § 54.1-3007(2), (5) and (8) and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations in that 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.

See Confidential Attachment I for the names of the patients referenced above.

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

Date June 21st, 2016