

**VIRGINIA:**

**BEFORE THE BOARD OF NURSING**

**IN RE: CRYSTAL G. YOUNG, R.M.A.  
Registration No.: 0031-001753**

**ORDER**

In accordance with §§ 2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), an informal conference was conducted on behalf of the Board of Nursing ("Board") on March 10, 2016, in Henrico County, Virginia. Ms. Young was not present nor was she represented by legal counsel. Jane Elliott, R.N., Ph.D., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On May 18, 2016, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Young was not present nor was she represented by legal counsel.

Based upon its review of the Recommended Decision of the Agency Subordinate, the Board makes the following Findings of Fact and Conclusions of Law and issues the following Order.

**FINDINGS OF FACT**

1. Crystal G. Young, R.M.A. was issued Registration No. 0031-001753 to practice as a medication aide in Virginia on December 22, 2008. The registration is scheduled to expire on May 31, 2016. Ms. Young also holds Certificate No. 1401-117146 to practice as a nurse aide in Virginia.

2. By letter dated February 16, 2016, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Young notifying her that an informal conference would be held on March 10, 2016. The Notice was sent by certified and first class mail to Post Office Box 16064, Bristol, Virginia 24209, the address of record on file with the Board of Nursing. The certified mail receipt was signed and returned to the Board office. The Notice sent by first class mail was not returned to the Board office. The Agency Subordinate concluded that adequate notice was provided to Ms. Young and the informal

conference proceeded in her absence.

3. During the course of her employment as a medication technician with Greendale Home for the Aged, Abingdon, Virginia, an inspection conducted by the Department of Social Services on April 21, 2015 revealed the following errors:

a. Ms. Young used the same glucometer to test blood sugar for multiple residents and failed to clean the glucometer between uses.

b. Ms. Young failed to properly administer medications in accordance with physicians' orders, as evidenced by the following:

i. Ms. Young dropped one tablet of levothyroxine 88mg prescribed daily to a resident. Ms. Young then threw out the tablet, and did not get a new one to administer.

ii. Ms. Young failed to administer sodium chloride to a resident, who was prescribed one gram daily.

iii. Ms. Young failed to watch a resident drink her prescribed can of Ensure.

iv. Ms. Young administered 12 units plus 10 units sliding scale of Novolog after breakfast to a resident who was prescribed 12 units of Novolog before breakfast. Further, Ms. Young administered 68 units of Levemir at 8:30 a.m. to the same resident, who was not scheduled to receive the medication until 10:00 a.m.

c. Ms. Young administered 10 units of Novolin 70/30 to a resident, and failed to document administration in the resident's MAR.

4. No patients suffered any harm as a result of these incidents.

5. As a result of these incidents, Greendale Home for the Aged issued Ms. Young final written discipline, demoted Ms. Young from her medication technician position to a direct care provider

position with a reduction in salary, and placed Ms. Young on 90 days of probation.

6. On September 23, 2015, Ms. Young told an investigator for the Department of Health Professions that her errors were unintentional. Ms. Young stated that she was using the equipment the facility provided and the delay in medication administration was due to the inspectors asking her many questions while she tried to complete the medication pass.

7. Previously, on January 10, 2014, the Board reprimanded Ms. Young for multiple medication administration errors and reusing for a lancet device and glucometer without properly sanitizing them.

### CONCLUSIONS OF LAW

Findings of Fact Nos. 3(a) through 3(c) constitute a violation of § 54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-60-120(2)(d), (f), (l), and (m) and 18 VAC 90-60-110(A)(2) of the Regulations Governing the Registration of Medication Aides.

### ORDER

WHEREFORE, it is hereby ORDERED as follows:

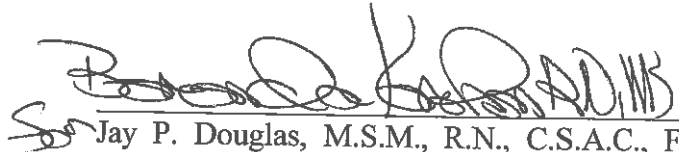
1. Crystal G. Young, R.M.A. is hereby REPRIMANDED.
2. Ms. Young shall maintain a course of conduct in her capacity as a registered medication aide commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

Pursuant to § 54.1-2400.2 of the Code, 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.

Since Ms. Young failed to appear at the informal conference, this Order shall be considered final. Ms. Young has the right to appeal this Order directly to the appropriate Virginia circuit court. As

provided by Rule 2A:2 of the Supreme Court of Virginia, Ms. Young has thirty (30) days from the date of service (the date she actually received this decision or the date it was mailed to her, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, M.S.M., R.N., C.S.A.C., F.R.E., Executive Director, Board of Nursing, at Perimeter Center, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

FOR THE BOARD

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

Entered: May 25, 2016

Certified True Copy

By   
Virginia Board Of Nursing