VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: **AMY DOOLEY, L.P.N.**
License No.: 0002-081570

CONSENT ORDER

By letter dated February 25, 2016, the Virginia Board of Nursing ("Board") noticed Ms. Dooley of a formal administrative hearing. In lieu of proceeding to a formal hearing, the Board and Amy Dooley, L.P.N., as evidenced by their signatures affixed below, enter into the following Consent Order affecting Ms. Dooley's license to practice practical nursing in Virginia.

The Board adopts the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Amy Dooley, L.P.N., was issued License No. 0002-081570 to practice practical nursing in the Commonwealth of Virginia on November 25, 2009. Said license is set to expire on December 31, 2017. Ms. Dooley's primary state of residence is Virginia.

2. On April 1, 2013, while receiving treatment with Carilion Clinic, Vinton Parkway Family Practice, Vinton, Virginia, Ms. Dooley displayed drug-seeking behaviors. Ms. Dooley was inconsistent with what she told the nurse and the prescriber about her medications, her prescription history showed that she had multiple narcotics prescribed from multiple providers within the last six months, and a urine drug screen indicated "barbital" (sic) [butalbitol] consumption, but she had not informed the practice about any prescription that would have provided such a result.

3. On September 11, 2014, Ms. Dooley signed a Controlled Substance Management Contract with Carilion Clinic, Vinton Parkway Family Practice; however, on September 29, 2014, Ms. Dooley's physician declined to prescribe her any additional narcotic medications because she had a positive drug screen for amphetamines and a subsequent urine drug screen failed to show results for any of the medications she was prescribed. Ms. Dooley was subsequently dismissed from the practice on December 15, 2014.

4. Between February 10, 2012 and February 10, 2015, Ms. Dooley was prescribed a total of 1,186 tablets of hydrocodone/acetaminophen (C-II) from 14 providers. Her medical records indicated various complaints of pain from multiple areas of her body and frequent office visits for complaints of pain in different areas, within short periods of time. Records indicated that Ms. Dooley refused any treatment involving physical therapy, injections and/or surgery.

5. On April 7, 2015, Ms. Dooley submitted to a urine drug screen at the request of the Department of Health Professions ("DHP") investigator. The results were positive for alcohol and were "invalid" concerning testing for other substances. The result showed an abnormal pH level, consistent with tampering. Ms. Dooley had been working for Maxim Healthcare on April 7, 2015, prior to driving to LabCorp to submit to the urine drug screen.

6. During the course of her employment with Bedford County Nursing Home, Bedford, Virginia, Ms. Dooley diverted narcotic pain medications for her own personal and/or unauthorized use, falsified medication administration records and documented and/or administered medications against physicians' orders, as evidenced by the following:

a. During her care of Resident A:

i. Between October 6, 2014 and October 22, 2014, Ms. Dooley signed out 24 tablets of Norco (hydrocodone-acetaminophen 5/325, C-II) on the controlled substance log, but she failed to document administration of 12 of the tablets. In addition, some of the administered tablets were documented over an hour after Ms. Dooley signed them out, and some tablets were signed out hours prior to their ordered time of administration. On or about October 22, 2014, a urine drug screen for Resident A was negative for opiates.

ii. On October 15, 2014, October 16, 2014 and October 17, 2014, Ms. Dooley documented that she administered a total of three tablets of Norco to Resident A, but she never signed the medication out on the controlled substance log.

b. During her care of Resident B:

i. On August 16, 2014, Ms. Dooley signed out two tablets of Norco for Resident B at 12:00 p.m. on the controlled substance log but she failed to document administration of the two tablets. In addition, the medication was to be given two tablets twice daily and was routinely administered at 9:00 a.m. and 9:00 p.m., and she documented that she had administered two tablets to Resident B at 9:00 a.m.

ii. Between October 8, 2014 and October 14, 2014, Ms. Dooley signed out a total of 12 tablets of Norco for Resident B but she failed to document administration of 6 of the tablets. In addition, Ms. Dooley frequently administered Norco to Resident B contrary to physician orders. Norco was ordered to be administered two tablets, twice daily, and was scheduled at 9:00 a.m. and 9:00 p.m.; however, Ms. Dooley often signed out only one tablet for the morning dose then signed out one tablet around the noon hour.

iii. On October 13, 2014, Ms. Dooley signed out one tablet of Norco for Resident B in the following order on the controlled substance log: 9:30 a.m., 12:00 p.m., and 9:30 a.m. Thereby, Ms. Dooley created multiple entries for approximately the same time on the same date.

iv. On October 15, 2014, Ms. Dooley documented that she administered two tablets of Norco to Resident B, but she never signed out the medication on the controlled substance log.

v. On October 22, 2014, Ms. Dooley signed out two tablets of Norco for Resident B at 7:45 a.m., 9:00 a.m., and 12:00 p.m., but she only documented administration of two tablets at 9:00 a.m.

c. During her care of Resident C:

i. On October 12, 2014, October 14, 2014 and October 22, 2014, Ms. Dooley signed out a total of 10 tablets of Norco for Resident C on the controlled substance log, but she failed to document administration of 4 of the tablets. In addition, Ms. Dooley frequently signed out tablets less than two hours after she had previously signed out the same medication for Resident C. Norco was ordered to be administered one tablet by mouth, three times daily and every four hours as needed.

ii. Between October 15, 2014 and October 21, 2014, Ms. Dooley documented that she administered nine tablets of Norco to Resident C, but she failed to sign out the tablets on the controlled substance log at or near the times of the documented administration.

d. During her care of Resident D:

i. On August 16, 2014, at approximately 1:30 p.m., Ms. Dooley signed out one tablet of Norco for Resident D on the controlled substance log, but she failed to document administration of the medication.

ii. Between October 12, 2014 and October 14, 2014, Ms. Dooley signed out a total of 10 tablets of Norco for Resident D on the controlled substance log, but she failed to document administration of 7 of the tablets. In addition, on October 12, 2014, Ms. Dooley signed out one tablet of Norco at 8:15 a.m., 8:30 a.m., 12:00 p.m., and 12:30 p.m. and, on October 14, 2014, Ms. Dooley signed out one tablet of Norco at 7:00 a.m., 8:20 a.m., 10:00 a.m. and 1:30 p.m., but the medication was ordered to be given one tablet each morning, then every six hours as needed.

iii. Between October 15, 2014 and October 17, 2014, Ms. Dooley documented that she administered four tablets of Norco to Resident D, but she failed to sign the medication out on the controlled substance log at or near the times of the documented administration.

e. During her care of Resident E:

i. On October 14, 2014 and October 21, 2014, Ms. Dooley signed out two tablets of oxycodone (C-II) for Resident E on the controlled substance log, but she failed to document administration of the medication.

ii. On September 28, 2014, October 12, 2014, and October 16, 2014, Ms. Dooley documented administration of oxycodone prior to signing it out on the controlled substance log.

iii. On October 22, 2014, Ms. Dooley documented that she administered oxycodone at 10:41 a.m., but she never signed out the medication.

7. During the course of her employment with Berkshire Health and Rehabilitation, Vinton, Virginia, Ms. Dooley diverted narcotic medications for her own personal and/or unauthorized use and falsely documented medication administration in that, during Ms. Dooley's care of Resident F:

a. On January 20, 2014, Ms. Dooley entered a nursing note that indicated that she had administered oxycodone to Resident F; however, she failed to document the medication administration on the resident's medication administration record ("MAR").

b. Between January 25, 2014 and February 13, 2014, Ms. Dooley documented that she administered oxycodone, which was prescribed to be administered as needed for pain, to Resident F on eight occasions. However, no nurse other than Ms. Dooley administered this medication to Resident F during this time period.

c. Between March 13, 2014 and April 7, 2014, Ms. Dooley documented that she administered hydrocodone-acetaminophen to Resident F on 19 occasions, but the medication was only administered on two occasions by another nurse. On April 9, 2014, the order for hydrocodone-acetaminophen was discontinued because the resident was not complaining of pain or discomfort.

d. On March 13, 2014, Ms. Dooley documented in the nursing notes that she administered hydrocodone-acetaminophen to Resident F, but she failed to document the administration in the resident's MAR.

8. On her application for employment with Bedford County Nursing Home, dated April 12, 2014, Ms. Dooley falsely indicated that she was terminated from Berkshire Health and Rehabilitation because of a complaint regarding a haircut and a shave. Additionally, she reported that she was never written up while employed with Berkshire Health and Rehabilitation. Ms. Dooley's employment with Berkshire Health and Rehabilitation was terminated on April 11, 2014, for poor customer service, sleeping or dozing at the medication cart and cell phone use, and she was written up on four occasions.

9. On her application for employment with Maxim Healthcare Services, Roanoke, Virginia, dated October 27, 2014, Ms. Dooley falsely indicated that she was terminated from Berkshire Health and Rehabilitation after an "injury and I sued them." However, her employment with Berkshire Health and Rehabilitation was terminated on April 11, 2014, for poor customer service, sleeping or dozing at the medication cart and cell phone use. In addition, Ms. Dooley falsely indicated that she was terminated from Bedford County Nursing Home for poor documentation. Her employment with Bedford County Nursing Home was terminated on October 24, 2014, for documentation and reconciliation of narcotics, failure to follow physician's orders and failure to assess pain and provide intervention prior to administering medications.

10. On April 6, 2015, during an interview with the DHP investigator, Ms. Dooley falsely stated that she was not aware of the allegations concerning her sleeping while on the medication cart at Berkshire Health and Rehabilitation. However, Ms. Dooley signed an employee corrective action form concerning the allegation, and wrote a statement to the facility about the allegation on April 8, 2014.

CONCLUSIONS OF LAW

1. Finding of Fact Nos. 2 through 5 constitute a violation of §54.1-3007(6) of the Code.

2. Finding of Fact No. 6 constitutes a violation of §54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(a), (c), (e), and (f) of the Regulations Governing the Practice of Nursing ("Regulations").

3. Finding of Fact No. 7 constitutes a violation of §54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) of the Regulations.

4. Findings of Fact Nos. 8 and 9 constitute a violation of §54.1-3007(2) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Regulations.

5. Finding of Fact No. 10 constitutes a violation of §54.1-3007(2) of the Code and 18 VAC 90-20-300(A)(2)(n) of the Regulations.

CONSENT

Amy Dooley, L.P.N., by affixing her signature hereon, agrees to the following:

1. She has been advised to seek advice of counsel prior to signing this document;

2. She acknowledges that without her consent, no legal action can be taken against her except pursuant to the Virginia Administrative Process Act, § 2.2-4000(A) *et seq*. of the Code;

3. She acknowledges that she has the following rights, among others: the right to a formal fact finding hearing before the Board, the right to reasonable notice of said hearing, the right to representation by counsel, and the right to cross-examine witnesses against her;

4. She waives all such right to a formal hearing;

5. She neither admits nor denies the Findings of Fact and Conclusions of Law contained herein but waives her right to contest such Findings of Fact and Conclusions of Law in any subsequent proceeding before the Board;

6. She consents to the entry of the following Order affecting her right to practice practical nursing in Virginia.

ORDER

WHEREFORE, on the basis of the foregoing, the Virginia Board of Nursing, effective upon entry of this Order, and in lieu of further proceedings, hereby ORDERS as follows:

1. License No. 0002-081570 of Amy Dooley, L.P.N., is INDEFINITELY SUSPENDED.

2. The license will be recorded as suspended and no longer current.

3. At such time as Ms. Dooley shall petition the Board for reinstatement of her license, an administrative proceeding will be convened to determine whether she is capable of resuming the safe and competent practice of practical nursing. Ms. Dooley shall be responsible for any fees that may be required for the reinstatement and renewal of the license prior to issuance of the license to resume practice.

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

5. This suspension shall be STAYED upon proof of entry into the Health Practitioners' Monitoring Program ("HPMP") and compliance with a Recovery Monitoring Contract with the HPMP pursuant to Chapter 25.1 of Title 54.1 of the Code and 18 VAC 76-10-10 *et seq*. of the Regulations Governing the HPMP. At such time, the indefinite suspension shall be STAYED and the following terms and conditions shall apply:

a. Ms. Dooley shall comply with all terms and conditions for the period specified by the HPMP.

b. Any violation of the terms and conditions stated in this Order shall be reason for summarily rescinding the stay of indefinite suspension of the license of Ms. Dooley, and an administrative proceeding shall be held to determine whether her license shall be revoked. The stay of indefinite suspension may be summarily rescinded at such time the Board is notified that:

i. Ms. Dooley is not in compliance with the terms and conditions specified by the HPMP;

ii. Ms. Dooley's participation in the HPMP has been terminated;

iii. There is a pending investigation or unresolved allegation against Ms. Dooley involving a violation of law, regulation, or any term or condition of this order.

6. Upon receipt of evidence of Ms. Dooley's participation and successful completion of the HPMP, the Board, at its discretion, may waive Ms. Dooley's appearance before a Committee and conduct an administrative review of this matter, at which time she may be issued an unrestricted license.

7. This Order is applicable to Ms. Dooley's multistate licensure privileges, if any, to practice practical nursing. For the duration of this Order, Ms. Dooley shall not work outside of the Commonwealth of Virginia pursuant to a multistate licensure privilege without the written permission of the Virginia Board of Nursing and the Board of Nursing in the party state where Ms. Dooley wishes to work. Any requests for out of state employment should be directed, in writing, to the Executive Director of the Board.

8. Ms. Dooley shall maintain a course of conduct in her capacity as a practical nurse 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.

Pursuant to Section 54.1-2400(10) of the Code, Ms. Dooley may, not later than 5:00 p.m., on May 10, 2016, notify Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he/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.

FOR THE BOARD

Joyce A. Hahn, PhD, RN, NEA-BC, FNAP 5/19/16
President, Virginia Board of Nursing

SEEN AND AGREED TO:

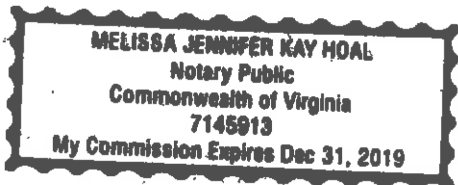
Amy Dooley, L.P.N.

COMMONWEALTH OF VIRGINIA,
COUNTY/CITY OF Roanoke, TO WIT: Amy Dooley

Subscribed and sworn to before me, Melissa Hoal, a Notary Public, this 11th day of April, 2016.

My commission expires 12/31/2019.

Registration Number 7145913.



NOTARY PUBLIC

Certified True Copy
By agraham
Virginia Board Of Nursing