VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: WILLIAM DEAN, R.N.

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 July 1, 2008 in Henrico County, Virginia. Mr. Dean was not present nor was he represented by legal counsel. Janet Younger, Ph.D., R.N., P.N.P., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On September 17, 2008, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Mr. Dean was not present nor was he 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. William Dean was issued License No. 0001-160434 to practice professional nursing in Virginia on July 24, 1998. The license is current.

2. By letter dated June 4, 2008, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Mr. Dean notifying him that an informal conference would be held on July 1, 2008. The Notice was sent by certified and first class mail to 68 Major Street, Lebanon, Virginia 24266, the address of record on file with the Board of Nursing, and to 5302 Woodland Terrace, Tuscaloosa, Alabama 35405, a secondary address. The certified mail receipt sent to the Alabama address was signed by Mr. Dean. The Agency Subordinate determined that Mr. Dean received adequate notice and the informal conference proceeded in his absence.

3. During the course of Mr. Dean's employment with Carilion Roanoke Memorial Rehabilitation Center, Roanoke, Virginia, he diverted controlled substances for his own personal and unauthorized use. A review of medications that Mr. Dean withdrew from the Pyxis from March 1, 2007 through April 2, 2007, disclosed the following discrepancies:

a. On March 2, 2007, at 7:27 p.m., he withdrew one Fentanyl 25mcg/HR patch (Schedule II) for Patient A. However, he failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the medication administration record ("MAR") or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 3, not March 2.

b. On March 3, 2007, at 9:27 p.m., he withdrew one Fentanyl 100mcg/HR patch for Patient B. However, he failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the MAR or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 5, not March 3.

c. On March 5, 2007, at 6:13 a.m., he withdrew one Oxycodone 5mg tablet (Schedule II) for Patient B; however, he charted administering 10 mg of Oxycodone.

d. On March 5, 2007, at 6:28 a.m., he withdrew two Hydrocodone/APPA 7.5/500mg tablets (Schedule III) for Patient C. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document whether the medication was returned or wasted.

e. On March 9, 2007, at 9:33 p.m., he withdrew one Lorazepam 1mg tablet (Schedule IV) for Patient D and documented administering 0.5mg. However, he failed to document wasting the remaining 0.5mg.

f. On March 10, 2007, at 2:57 a.m., he withdrew one Fentanyl 100mcg/HR patch for Patient D. However, he failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the MAR or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 12, not March 10.

g. On March 10, 2007, at 7:31 p.m., he withdrew one Oxycodone CR 20mg tablet (Schedule II) for Patient E. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately 46 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours.

h. On March 11, 2007, at 7: 52 p.m., he withdrew one Oxycodone CR 20mg tablet for Patient E. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately 12 minutes after another nurse had withdrawn and documented as administered the same medication for this patient. The physician's order was to administer the medication every 12 hours.

i. On March 11, 2007, at 7:56p.m., he withdrew one Morphine 20mg/1ml (Schedule II) for Patient D and documented administering Morphine 10mg; however, he failed to document wasting the remaining 10mg.

j. On March 11, 2007 at 11:39p.m., he withdrew one Morphine 20mg/1ml for Patient D and documented administering Morphine 10mg; however, he failed to document wasting the remaining 10mg.

k. On March 12, 2007, at 6:00 a.m., he withdrew one Oxycodone CR 20mg tablet for Patient F. However he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately one minute after another nurse had withdrawn and documented as administered this same medication for this patient.

l. On March 12, 2007, at 6:29 a.m., he withdrew one Oxycodone CR 20mg tablet for Patient E. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately 18 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours as needed.

m. On March 16, 2007, at 7:47 p.m., he withdrew one Oxycodone CR 20mg tablet for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately 54 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours as needed.

n. On March 16, 2007, at 10:09 p.m., he withdrew one Oxycodone CR 5mg tablet for Patient F. However he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately one hour and 13 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every four hours as needed.

o. On March 16, 2007, at 11:34 p.m., he withdrew two Hydrocodone/APAP 7.5/500 tablets for Patient C. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

p. On March 16, 2007, at 11:34 p.m., he withdrew two Zolpidem Tartrate 5mg tablets for Patient C. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

q. On March 16, 2007, at 11:52 p.m., he withdrew two Oxycodone 5mg tablets for Patient B. However he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

r. On March 17, 2007, at 3:58 a.m., he withdrew one Oxycodone 5mg tablet for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

s. On March 17, 2007, at 7:33 p.m., he withdrew one Fentanyl 100mcg/HR patch for Patient B. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately two hours after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 72 hours.

t. On March 17, 2007, at 9:31 p.m., he withdrew one Lorazepam 1mg tablet for Patient D and documented administering 0.5mg. However, he failed to document that the remaining 0.5mg was wasted.

u. On March 17, 2007, at 9:32 p.m., he withdrew one Morphine 20mg/1ml for Patient D and documented administering 10mg. However, he failed to document wasting the

remaining 10mg.

v. On March 18, 2007, at 4:05 a.m., he withdrew two Oxycodone 5mg tablets for Patient B. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

w. On March 18, 2007, at 4:50 a.m., he withdrew one Oxycodone 5mg tablet for Patient B. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was wasted. The physician's order was to administer this medication every four hours as needed.

x. On March 19, 2007, at 12:00 a.m., he withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one Oxycodone 5mg tablet. However, he failed to document that the remaining 5mg tablet was returned or wasted.

y. On March 23, 2007, at 7:54 p.m., he withdrew one Oxycodone 5mg tablet for Patient F and documented the administration of the medication. At 8:12 p.m., he withdrew one Oxycodone 5mg tablet for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

z. On March 23, 2007, at 11:24 p.m., he withdrew one Oxycodone 5mg tablet for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document the medication was returned or wasted.

aa. On March 23, 2007, at 11:54 p.m., he withdrew one Oxycodone 5mg tablet for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

bb. On March 23, 2007, at 11:54 p.m., he withdrew one Zolpidem Tartrate 5mg tablet for Patient C. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

cc. On March 24, 2007, at 6:03 a.m., he withdrew two Hydrocodone/APAP 7.5/500mg tablets for Patient C. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

dd. On March 24, 2007, at 6:03 a.m., he withdrew two Oxycodone 5mg tablets for Patient G. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

ee. On March 24, 2007, at 7:26 p.m., he withdrew two Oxycodone 5mg tablets for Patient G. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

ff. On March 24, 2007, at 8:18 p.m., he withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one 5mg tablet; however, he failed to document that the remaining 5mg tablet was returned or wasted.

gg. On March 25, 2007, at 4:42 a.m., he withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one 5mg tablet; however, he failed to document that the remaining 5mg tablet was returned or wasted.

hh. On March 25, 2007, at 11:46 p.m., on two separate occasions at 11:46 p.m., he withdrew one Oxycodone 5mg tablet each time for Patient H. He documented administering one of the tablets; however, he failed to document that the remaining 5mg tablet was returned or wasted.

ii. On March 26, 2007, at 12:14 a.m., he withdrew one Hydrocodone/APAP tablet for Patient I. However, he failed to document the administration of this medication on the MAR or in

the nursing notes; nor did he document that the medication was returned or wasted.

jj. On March 26, 2007, at 3:18 a.m., he withdrew two Oxycodone 5mg tablets and documented the administration of the medication to Patient G. At 4:08 a.m., he withdrew two Oxycodone 5mg tablets for Patient G. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. The physician's order was to administer the medication every four hours as needed.

kk. On March 26, 2007, at 11:43 p.m., he withdrew two Oxycodone 5mg tablets for Patient F. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

ll. On March 27, 2007, at 12:38 a.m., he withdrew three Methadone 5mg tablets (Schedule II) for Patient G. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

mm. On March 28, 2007, at 11:26 p.m., he withdrew one Oxycodone 5mg tablet for Patient J. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

nn. On March 28, 2007, at 11:26 p.m., he withdrew one Oxycodone 5mg tablet for Patient K. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

oo. On March 29, 2007, at 12:46 a.m., he withdrew two Oxycodone 5mg tablets for Patient L. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

pp. On March 29, 2007, at 3:27 a.m., he withdrew one Oxycodone 5mg tablet for

Patient J. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

qq. On March 29, 2007, at 5:56 a.m., he withdrew two Oxycodone 5mg tablets for Patient H. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately six minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication three times a day.

rr. On March 30, 2007, at 9:20 p.m., he withdrew one Oxycodone CR 20mg tablet for Patient M. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately four hours after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours.

ss. On April 1, 2007, at 12:08 a.m., he withdrew two Oxycodone 5mg tablets for Patient H. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. Further, he signed out this medication approximately one hour after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication three times a day.

tt. On April 1, 2007, at 3:03 a.m., he withdrew two Oxycodone 5mg tablets for Patient G. However he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

uu. On April 1, 2007, at 7:31 p.m., he withdrew one Oxycodone 5mg tablet for Patient K. However he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

vv. On April 1, 2007, at 10:09 p.m., he withdrew two Oxycodone 5mg tablets for Patient L. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

ww. On April 2, 2007, at 12:11 a.m., he withdrew one Zolpidem Tartrate 5mg tablet for Patient L. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted.

xx. On April 2, 2007, at 5:52 a.m., he withdrew one Oxycodone CR 20mg tablet for Patient M and documented the administration of the medication. At 5:55 a.m., he withdrew one Oxycodone CR 20mg tablets for Patient M. However, he failed to document the administration of this medication on the MAR or in the nursing notes; nor did he document that the medication was returned or wasted. The physician's order was to administer the medication every 12 hours as needed.

yy. On April 2, 2007, at 6:12 a.m., he withdrew one Oxycodone 5mg tablet for Patient L; however, he charted administering 10mg of Oxycodone.

4. On July 8, 2002, the Rhode Island Board of Nursing denied Mr. Dean's application for licensure due to drug diversion.

5. On November 23, 2004, Mr. Dean submitted an Application for Employment with Carilion wherein he responded "[n]o" to the question "[h]ave you received disciplinary action, been placed on probation, or been investigated by any state licensing board(s)" when, in fact, he had been denied licensure in Rhode Island.

CONCLUSIONS OF LAW

1. Findings of Fact No. 3(a) through 3(yy) constitute a violation of § 54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) of the Board of Nursing Regulations.

2. Finding of Fact No. 4 constitutes a violation of § 54.1-3007(7) of the Code.

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

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. License No. 0001-160434 of William Dean, R.N. is INDEFINITELY SUSPENDED for a period of not less than two years.

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

3. At such time as Mr. Dean shall petition the Board for reinstatement of his license, an administrative proceeding will be convened to determine whether he is capable of resuming the safe and competent practice of professional nursing. Mr. Dean 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 professional nursing.

Since Mr. Dean failed to appear at the informal conference, this Order shall be considered final. Mr. Dean 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, Mr. Dean has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, R.N., M.S.M., C.S.A.C., 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.

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.

FOR THE BOARD

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

Entered: September 30th, 2008

Certificate of Service

I hereby certify that a true copy of the foregoing Order was mailed this day to William Dean at 68 Major Street, Lebanon, Virginia 24266 and at 5302 Woodland Terrace, Tuscaloosa, Alabama 35405.

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

September 30th, 2008
DATE