VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: KAREN COX, R.N. REINSTATEMENT APPLICANT
License No.: 0001-193618

ORDER

Pursuant to §§ 2.2-4020, 54.1-110 and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was held before a panel of the Board of Nursing ("Board") on November 18, 2015, in Henrico County, Virginia, to receive and act upon Karen Cox's application for reinstatement of her license to practice professional nursing in Virginia and to inquire into evidence that Ms. Cox may have violated certain laws and regulations governing nursing practice in Virginia. The case was presented by Cynthia E. Gaines, Adjudication Specialist, Administrative Proceedings Division. James Rutkowski, Assistant Attorney General, was present as legal counsel for the Board. Ms. Cox was present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Karen Cox, R.N., was issued License No. 0001-193618 to practice professional nursing in the Commonwealth on November 17, 2004. Ms. Cox's license to practice professional nursing was mandatorily suspended pursuant to § 54.1-2409 of the Code by Order of the Department of Health Professions entered on February 2, 2015.

2. Ms. Cox submitted an application for reinstatement of her license to practice professional nursing which was received by the Board on April 9, 2015. Ms. Cox declared her primary state of residence as Virginia.

3. During the course of her employment with MSA Home Health and Hospice, Richlands, Virginia, Ms. Cox diverted Duragesic (C-II) patches prescribed to hospice patients for her own personal and/or otherwise unauthorized use, failed to maintain accurate clinical notes and failed to follow physician orders, as evidenced by the following:

a. Between October 2013 and January 2014 Ms. Cox had single Duragesic patch prescriptions filled at multiple pharmacies and received the medications from multiple pharmacies for Patient A. The prescriptions should have totaled approximately 85 patches; she received approximately 100 patches, as evidenced by her signature on pharmacy signature records. In addition, she failed to document administration of the medication in clinical notes and she failed to follow physician orders regarding the patches. Duragesic patches were ordered to remain in place for 72 hours; by her own admission, she did not ensure the patches were placed at three-day intervals and she sometimes changed the patches early.

b. On April 11, 2014 and April 23, 2014 Ms. Cox received Duragesic patches prescribed to Patient B from the pharmacy, as evidenced by her signature on the pharmacy signature records. However, her clinical notes dated April 8, 2014 did not mention Patient B experiencing pain and indicated that the physician did not need to be contacted, and Patient B was not prescribed Duragesic patches for pain. On April 11, 2014 she received a prescription for 50 mcg Duragesic patches for Patient B, but according to her clinical notes, she was not at Patient B's home again until April 17, 2014. On that date, her clinical notes do not mention any pain being experienced by Patient B, it was noted that physician contact was not needed, and medication education was not given to the caregivers about a new medication. The dosage of the Duragesic patches was increased on April 23, 2014, and Ms. Cox received the patches the same day from the pharmacy; by her own admission, she did not know whether the patches were being used. The patient's son indicated Patient B never experienced pain and never used Duragesic patches.

c. From February 26, 2013 to August 1, 2013 Ms. Cox had single Duragesic patch prescriptions filled at multiple pharmacies and she received the filled prescriptions from multiple pharmacies

for Patient C, as evidenced by her signature on pharmacy signature records. The prescriptions totaled approximately 70 patches; she picked up approximately 120 patches. The patches were to remain in place for 72 hours per physician orders; however, clinical notes indicated she did not follow the physician's order. From March 14, 2013 to March 26, 2013 the count remained three patches; from March 28, 2013 to April 3, 2013 she indicated four patches were used. The clinical and nurses' notes for Patient C failed to maintain accurate medication counts and/or failed to note Duragesic patches as a medication prescribed to Patient C. When Patient C's family indicated to Ms. Cox that his pain was not well controlled, she informed them it was because of the patient's tolerance.

d. Between August 2013 and October 2013 Ms. Cox filled single prescriptions for Duragesic patches for Patient D at multiple pharmacies and received the prescriptions from multiple pharmacies as evidenced by her signature on pharmacy signature records. Patient D received a prescription for Duragesic patches on or about August 19, 2013 and Ms. Cox received the medication on that date. Her clinical and nurses' notes failed to mention that Patient's D's pain was not managed by the Lortab prescribed and she failed to note Duragesic patches as a medication for Patient D until September 6, 2013. The prescriptions should have totaled approximately 35 patches; she picked up approximately 59 patches. Patient D passed away on October 4, 2013; Ms. Cox received a prescription for five Duragesic patches from the pharmacy for Patient D on October 7, 2013 knowing he was deceased.

e. On November 6, 2013 Ms. Cox had filled and received a prescription for Patient E for Duragesic patches from Bristol Home Infusion, as evidenced by her signature on pharmacy signature records, knowing the patient did not use that pharmacy, and that the medication was normally filled and picked up at another pharmacy by the patient's caregivers. Patient E passed away on November 15, 2013 and, by her own admission, Ms. Cox took the deceased's medications with her from the residence.

4. Ms. Cox receives opioid addiction treatment from Watauga Medical Group, P.C., Abingdon, Virginia. She had been prescribed Zubsolv, 5.7 mg/1.4 mg (buprenorphine and nalaxone, Schedule III),

since May 2014.

5. On her employment application to Stone Mountain Health Services, Pennington Gap, Virginia, dated May 25, 2014, Ms. Cox indicated her reason for leaving MSA Home Health and Hospice was because of a lack of patients when, in fact, she resigned when confronted with evidence of drug diversion.

6. On January 22, 2015, Ms. Cox was convicted of embezzlement, a felony, in the Circuit Court of Russell County, Virginia. This conviction formed the basis for the mandatory suspension of her nursing license by the Department of Health Professions.

7. Ms. Cox testified that her date of sobriety is April 10, 2014. She reported working a 12-step program. Ms. Cox signed a Participation Contract with the Health Practitioners' Monitoring Program on April 10, 2014 ("HPMP"), and a Recovery Monitoring Contract on February 23, 2015.

8 Ms. Cox's case manager from the HPMP testified that Ms. Cox was compliant with the program. The case manager also stated that Ms. Cox will be authorized to work if she receives her license.

9. Ms. Cox took full responsibility for her actions and even apologized to the Department of Health Professions investigator at the hearing for being untruthful during her interview.

10. Ms. Cox testified that she paid her restitution in full.

CONCLUSIONS OF LAW

The Board concludes that:

1. Findings of Fact Nos. 3(a) through 3(e) constitute a violation of §54.1-3007(2), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c), (e) and (f) of the Regulations Governing the Practice of Nursing Finding ("Regulations").

2. Finding of Fact No. 4 constitutes a violation of § 54.1-3007(6) 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 Regulations.

4. Finding of Fact No. 6 constitutes a violation of § 54.1-3007(4) of the Code.

ORDER

WHEREFORE, the Virginia Board of Nursing, by affirmative vote of at least three-fourths of the members of the Board at the hearing, effective upon entry of this Order, hereby ORDERS that License No. 0001-193618 issued to Karen Cox, R.N., to practice professional nursing in the Commonwealth of Virginia, be and hereby is REINSTATED contingent upon the following terms and conditions:

1. Ms. Cox remain compliant with the terms of a Recovery Monitoring Contract with the HPMP and the following terms and conditions:

a. Ms. Cox 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 revoking the license of Ms. Cox, and an administrative proceeding shall be held to decide whether her license should be revoked. Ms. Cox shall be noticed to appear before the Board at such time as the Board is notified that:

i. Ms. Cox is not in compliance with the terms and conditions of the HPMP, or has been terminated from participation in the HPMP;

ii. There is a pending investigation or unresolved allegation against Ms. Cox involving a violation of law or regulation or any term or condition of this Order; or

iii Ms. Cox has successfully completed the above-referenced period of participation in the HPMP. However, upon receipt of evidence of Ms. Cox's participation in and compliance with the HPMP, the Board, at its discretion, may waive Ms. Cox's appearance before the Board and conduct an administrative review of this matter.

2. This Order shall be applicable to Ms. Cox's multistate licensure privileges, if any, to practice professional nursing. It is further ordered that for the duration of this Order, Ms. Cox may 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 she wishes to work.

3. Ms. Cox is hereby REPRIMANDED.

4. Ms. Cox shall maintain a course of conduct in her capacity as a professional nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

Pursuant to §§ 2.2-4023 and 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 public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director
Virginia Board of Nursing

ENTERED December 10th, 2015

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 P. Douglas, MSM, RN, CSAC, FRE, 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