VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: KELLY M. CONN, R.N.
License No.: 0001-256220

NOTICE OF HEARING

Pursuant to §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), Kelly M. Conn, R.N., who, prior to its summary suspension by the Board of Nursing on August 27, 2015, held License No. 0001-256220 to practice professional nursing in Virginia, is hereby given notice that a formal administrative hearing will be held in the presence of a panel of the Board of Nursing. The hearing will be held on November 19, 2015, at 9:00 a.m., at the offices of the Department of Health Professions, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233, at which time Ms. Conn will be afforded the opportunity to be heard in person or by counsel.

At the hearing, Ms. Conn has the following rights, among others: the right to representation by counsel; the right to have witnesses subpoenaed and to present witnesses on her behalf; the right to present documentary evidence; and the right to cross-examine adverse witnesses. If Ms. Conn desires any witnesses to appear on her behalf, she must notify the Director of Administrative Proceedings, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in accordance with the Instructions for Requesting Subpoenas.

The purpose of the hearing is to inquire into evidence that Kelly Conn, R.N. may have violated certain laws and regulations governing nursing practice in Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board alleges that during the course of her employment with AMN Healthcare, a nurse staffing agency:

1. Kelly M. Conn, R.N. may have violated § 54.1-3007(5) and (6) of the Code as follows:

a. While assigned to Chippenham Johnston Willis Medical Center, Richmond, Virginia ("CJW"), on or about May 2, 2015, Ms. Conn appeared impaired while on duty. Specifically, she was noted to have slurred speech, glazed eyes, and a stumbling gait. She left the floor for over 30 minutes less than an hour after beginning her shift.

b. While assigned to Johns Hopkins Medical Center, Baltimore, Maryland, during orientation in or about January 2015, Ms. Conn was noted to be impaired, in that she appeared sleepy despite drinking a large amount of caffeine and made bizarre, inappropriate comments.

2. Ms. Conn may have violated § 54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) of the Regulations Governing the Practice of Nursing in that while assigned to CJW, she diverted narcotic medications from patient supplies for her unauthorized use or the use of another, as evidenced by the following:

a. On or about March 17, 2015, at 1619, Ms. Conn withdrew two oxycodone tablets (C-II) for Patient A, but failed to document administration of this medication. Further, she documented wasting 10 tablets at 1636 hours.

b. On or about March 18, 2015, at 2302, she withdrew one hydrocodone tablet (C-II) for Patient B, but failed to document administration of this medication. Further, she documented wasting "0" tablets at 2304 hours.

c. On or about March 23, 2015, at 2152, she withdrew 10ml Hycet (hydrocodone) for Patient C, who had an order for Hycet at 0800 and 1700. She then documented administering this medication at 2137 hours. She also noted at 1617, with respect to Hycet, "med not available at time of admin. PRN Norco given instead and hycet given now that it's available."

d. On or about March 24, 2015, at 1814, she withdrew one hydrocodone tablet for Patient D, but failed to document administration or wastage of this medication.

e. On or about March 25, 2015, at 1742, she withdrew one tablet of hydrocodone for Patient C, but failed to document administration or wastage of this medication. Patient C was discharged at 1752. Further, Ms. Conn had administered liquid hydrocodone to Patient C at 1700.

f. On or about March 29, 2015, at 2356, she withdrew two oxycodone tablets for Patient E, but failed to document administration of this medication. Further, at 2359, she documented wasting 10 oxycodone tablets.

g. On or about March 31, 2015, at 2224, she withdrew two oxycodone tablets for Patient E, but failed to document administration of this medication. Further, at 2307, she documented wasting "0" oxycodone.

h. On or about March 31, 2015, at 2234, she withdrew one hydrocodone tablet for Patient E, but failed to document administration or wastage of this medication.

i. On or about May 2, 2015, at 2145, she documented administering oxycodone to Patient F, who denied receiving the medication.

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

FOR THE BOARD

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

ENTERED: August 27th, 2015