Certified True Copy
By
Virginia Board of Nursing

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367-4400
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November 13, 2015

Terri Lynn Williams
8336 Telescope Peak Court
Las Vegas, NV 89145

CERTIFIED MAIL

DUPLICATE COPY
VIA FIRST CLASS MAIL
DATE 11/13/15

RE: License No.: 0002-087053

Dear Ms. Williams:

Pursuant to Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), you are hereby given notice that your license to practice nursing in the Commonwealth of Virginia has been mandatorily suspended by the enclosed Order entered November 13, 2015. You are hereby advised that, pursuant to Section 54.1-2409.1 of the Code, any person who practices a profession or occupation after having their license or certificate to do so suspended shall be guilty of a felony. Please return your license to Jay P. Douglas, Executive Director of the Virginia Board of Nursing, at the above address, immediately upon receipt of this letter.

Section 54.1-2409 of the Code further provides that you may apply to the Board of Nursing ("Board") for reinstatement of your license, and shall be entitled to a hearing not later than the next regular meeting of the Board after the expiration of sixty days from the receipt of such reinstatement application. You have the following rights, among others: to be represented by legal counsel, to have witnesses subpoenaed on your behalf, to present documentary evidence and to cross-examine adverse witnesses. The reinstatement of your license shall require the affirmative vote of three-fourths of the members present of the Board of Nursing.

Should you wish to petition the Board of Nursing for reinstatement of your license, contact Jay P. Douglas, Executive Director, at the above address or (804) 367-4599.

RECEIVED
NOV 16 2015
VA BD OF NURSING

Sincerely,

David E. Brown, D.C., Director
Department of Health Professions

Enclosures
Case # 170309

VIRGINIA:

BEFORE THE DEPARTMENT OF HEALTH PROFESSIONS

IN RE: TERRI LYNN WILLIAMS, L.P.N.
License No.: 0002-087053

ORDER

In accordance with Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), I, David E. Brown, D.C., Director of the Virginia Department of Health Professions, received and acted upon evidence that the license of Terri Lynn Williams, L.P.N., to practice nursing in the State of Nevada was revoked by an Order dated October 9, 2015. A certified copy of the Order is attached to this Order and is marked as Commonwealth's Exhibit No. 1.

WHEREFORE, by the authority vested in the Director of the Department of Health Professions pursuant to Section 54.1-2409 of the Code, it is hereby ORDERED that the license of Terri Lynn Williams, L.P.N., to practice nursing in the Commonwealth of Virginia be, and hereby is, SUSPENDED.

Upon entry of this Order, the license of Terri Lynn Williams, L.P.N., will be recorded as suspended and no longer current. Should Ms. Williams seek reinstatement of her license pursuant to Section 54.1-2409 of the Code, she shall be responsible for any fees that may be required for the reinstatement and renewal of her license prior to issuance of her license to resume practice.

Pursuant to Sections 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 a public record and shall be made available for public inspection and copying upon request.

David E. Brown, D.C., Director
Department of Health Professions

ENTERED: 11/13/15

COMMONWEALTH of VIRGINIA

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Director

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CERTIFICATION OF DUPLICATE RECORDS

I, David E. Brown, D.C., Director of the Department of Health Professions, hereby certify that the attached Order dated October 9, 2015, regarding Terri Lynn Williams, L.P.N., is a true copy of the records received from the Nevada State Board of Nursing.

David E. Brown, D.C.

Date: 11/13/15

ORIGINAL

BEFORE THE NEVADA STATE BOARD OF NURSING

IN THE MATTER OF TERRI WILLIAMS LICENSED PRACTICAL NURSE NEVADA LICENSE NO. LPN16527 RESPONDENT	FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER. CASE NO. 0248-15C

On Thursday, September 17th, 2015, a hearing was held in the above matter before the Nevada State Board of Nursing at the Tuscany Suites, 255 E. Flamingo Road, Las Vegas, NV 89169 in compliance with the provisions of Chapters 233B and 632 of the Nevada Revised Statutes (NRS) and Chapter 632 of the Nevada Administrative Code (NAC).

Respondent Terri Williams did not appear at the hearing. The Nevada State Board of Nursing staff appeared through counsel, Frederick R. Olmstead.

Based upon NAC 632.923, the Board proceeded to consider the case without the participation of Respondent. Based upon NAC 632.923, the Board considered the charges specified in the Complaint to be true. Accordingly, the Board made the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

I.

At least twenty-one (21) working days prior to the date of the hearing, Respondent had been noticed of the hearing by certified mail and by first class mail, which notice was mailed to Respondent's last known residential address.

II.

The Board had jurisdiction over the matter, and the Board could proceed to make a determination in the matter.

III.

On August 1, 2014, Respondent was initially issued a temporary license as a Licensed Practical Nurse (LPN) in the State of Nevada. On January 14, 2015, Respondent was issued a permanent LPN license in the State of Nevada.

From December 15, 2014, through December 23, 2014, Respondent was employed and working as an LPN at St. Joseph Transitional Rehabilitation Center in Las Vegas, Nevada. During that time, Respondent took the following actions:

On December 15, 2014, Respondent withdrew 2 tabs of 200mg Vimpat from the medication dispense machine. The physician's order was for 2 tabs of 200mg Vimpat. Respondent documented administration of 1 tab of Vimpat. Respondent did not document waste of remaining 1 tab of Vimpat.

On December 16, 2014, Respondent withdrew 2 tabs of 200mg Vimpat from the medication dispense machine. The physician's order was for 2 tabs of 200mg Vimpat. Respondent documented administration of 1 tab of Vimpat. Respondent did not document waste of remaining 1 tab of Vimpat.

On December 22, 2014, Respondent withdrew 2 tabs of 200mg Vimpat from the medication dispense machine. The physician's order was for 2 tabs of 200mg Vimpat. Respondent documented administration of 1 tab of Vimpat. Respondent did not document waste of remaining 1 tab of Vimpat.

On December 23, 2014, Respondent withdrew 2 tabs of 200mg Vimpat from the medication dispense machine. The physician's order was for 2 tabs of 200mg Vimpat. Respondent documented administration of 1 tab of Vimpat. Respondent did not document waste of remaining 1 tab of Vimpat.

On February 17, 2015, Respondent wrote a prescription for 15mg Oxycodone quantity 180 for patient A, which was not authorized by a physician. Respondent, then, stayed after hours to intercept the delivery of the medication from the pharmacy. Respondent signed for the controlled medications, which were not transferred to the patient's perpetual inventory card.

On March 2, 2015, Respondent wrote a prescription for 15mg Oxycodone quantity 180 for patient B, which was not authorized by a physician. Respondent, then, stayed after hours to intercept the delivery of the medication from the pharmacy. Respondent signed for the controlled medications, which were not transferred to the patient's perpetual inventory card.

On March 2, 2015, Respondent wrote a prescription for 10/325mg Percocet quantity 360 for patient C, which was not authorized by a physician. Respondent, then, stayed after hours to intercept the delivery of the medication from the pharmacy. Respondent signed for the controlled medications, which were not transferred to the patient's perpetual inventory card.

CONCLUSIONS OF LAW

1. Pursuant to NRS 632.320 and/or NAC 632.325 and/or NAC 632.923-927, the Board may take disciplinary action against the Respondent based upon proof of a violation of chapter 632 of the Nevada Revised Statutes and/or the Nevada Administrative Code.

2. Based on the charges specified in the Complaint being considered as true, due to Respondent's failure to appear at the hearing after proper notice was given, Respondent was found guilty of violating NRS 632.320(1)(g) unprofessional conduct, because Respondent violated NAC 632.890(2) when Respondent performed acts beyond the scope of the practice of nursing.

Respondent was also found guilty of violating NRS 632.320(1)(g) unprofessional conduct, because Respondent violated NAC 632.890(18) when Respondent diverted supplies, equipment or drugs for personal or unauthorized use.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law and good cause appearing therefore,

IT IS HEREBY ORDERED that pursuant to NRS 632.320 and/or NAC 632.926 (1)(h), Respondent's Nevada Practical Nurse's License No. LPN16527 is revoked. Respondent may not apply for reinstatement of her Nevada LPN license for a period of five years.

IT IS FURTHER ORDERED that the revocation shall become part of Respondent's permanent record, be published on the Board's list of disciplinary actions, and be reported to the appropriate data banks.

Pursuant to NRS 632.400(2), the ruling of the Board contained in these Findings of Fact, Conclusions of Law, and Order shall take effect upon service to the Respondent or when the Board receives a return from the United States Postal Service indicating the Respondent refused service or could not be located.

If no return is received by the Board, the order shall become effective 30 days from the date of the order.

DATED this 4th day of ~~September~~ October 2015.

NEVADA STATE BOARD OF NURSING

By: _____
Rhigel Tan, DNP, RN, APRN
Board President