

VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: ANGELA C. WOODRUFF, L.P.N.
License No.: 0002-060303

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 7, 2015, in Henrico County, Virginia. Angela C. Woodruff, L.P.N., was not present nor was she represented by legal counsel. Judith Piersall, R.N., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On September 16, 2015, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Woodruff was not present nor was she 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. Angela Woodruff, L.P.N., was issued License No. 0002-060303 to practice practical nursing in Virginia on July 14, 2000. The license is scheduled to expire on January 31, 2017. Ms. Woodruff's primary state of residence is Virginia.
2. By letter dated June 12, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Woodruff notifying her that an informal conference would be held on July 7, 2015. The Notice was sent by certified and first class mail to 124 Farmer's Circle, Hillsville, Virginia 24343, the address of record on file with the Board of Nursing. The Notice sent by certified mail was accepted

by Ms. Woodruff on June 15, 2015. As of July 7, 2015, the Notice sent by first class mail had not been returned to the Board office. The Agency Subordinate concluded that adequate notice was provided to Ms. Woodruff and the informal conference proceeded in her absence.

3. During the course of her employment with Trinity Mission Health and Rehabilitation, Hillsville, Virginia (“Trinity Mission”):

a. On September 29, 2014, Ms. Woodruff failed to assess Resident A, after being told that the resident was complaining of chest pain. Resident A had recently undergone a coronary artery bypass graft.

b. On September 28, 2014, Resident B had to be lowered to the floor twice during Ms. Woodruff’s shift. Ms. Woodruff failed to document the incidents, notify the resident’s physician or report the incidents to oncoming staff. Ms. Woodruff stated to the investigator for the Department of Health Professions that she believed that an incident report was not necessary because the resident did not fall.

c. On September 18, 2014, Ms. Woodruff administered to Resident C Valium 2.5mg (C-IV), when her physician had ordered 5mg of the medication.

d. On September 28, 2014, Ms. Woodruff administered to Resident D Xanax .25 mg (C-III) when his physician had ordered .5mg of the medication.

e. On September 18, 19, and 29, 2014, Ms. Woodruff failed to administer Clorazepate 15mg (C-III) to Resident E as ordered by her physician.

f. On September 29, 2014, Ms. Woodruff failed to administer Protonix 40 mg (C-VI) to Resident F as ordered by his physician.

4. Ms. Woodruff began employment with Trinity Mission in July 2014. Her orientation at the facility was extended until September 25, 2014 due to her continued difficulties with medication

administration. The Director of Nursing stated to the investigator for the Department of Health Professions that in the incidents that occurred on September 28, 2015, and September 29, 2015, Ms. Woodruff was working alone, following completion of orientation.

5. On October 16, 2014, Ms. Woodruff's employment with Trinity Mission was terminated.
6. Woodruff's practice for the previous 12 years was in an office setting.

CONCLUSIONS OF LAW

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

ORDER

WHEREFORE, it is hereby ORDERED as follows:

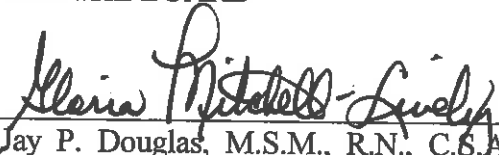
1. License No. 0002-060303 of Angela Woodruff to practice practical nursing is INDEFINITELY SUSPENDED.
2. The license will be recorded as suspended and no longer current.
3. The suspension shall end upon Ms. Woodruff providing the Board with evidence that she has successfully completed a nursing refresher course approved by the Board.
4. Ms. Woodruff 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.
5. This suspension applies to any multistate privilege to practice practical nursing.

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.

Since Ms. Woodruff failed to appear at the informal conference, this Order shall be considered final. Ms. Woodruff has the right to appeal this Order directly to the appropriate Virginia circuit court.

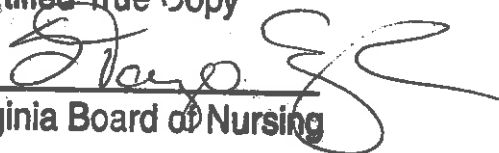
As provided by Rule 2A:2 of the Supreme Court of Virginia, Ms. Woodruff has 30 days from the date of service (the date she actually received this decision or the date it was mailed to her, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, M.S.M., R.N., C.S.A.C., F.R.E., 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.

FOR THE BOARD

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

Entered: October 7, 2015

Certified True Copy

By 
Virginia Board of Nursing