

**VIRGINIA:**

**BEFORE THE BOARD OF NURSING**

**IN RE: TUCK HINNANT, R.N.  
License No.: 0001-204799**

**ORDER**

Pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400(10) of the Code of Virginia (1950), as amended (“Code”), a Special Conference Committee (“Committee”) of the Virginia Board of Nursing (“Board”) met on June 8, 2015, in Henrico County, Virginia, to inquire into evidence that Tuck Hinnant, R.N., may have violated certain laws and regulations governing nursing practice in Virginia. Mr. Hinnant was present and was represented by Lisa Bertini, Esquire.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law.

**FINDINGS OF FACT**

1. Tuck Hinnant, R.N., was issued License No. 0001-204799 to practice professional nursing in the Commonwealth of Virginia on December 5, 2006. Said license expires on December 31, 2016. Mr. Hinnant’s primary state of residence is Virginia.

2. By letter dated March 23, 2015, the Board of Nursing sent a Notice of Informal Conference (“Notice”) to Mr. Hinnant notifying him that an informal conference would be held on April 21, 2015. The Notice was sent by certified and first class mail to 4801 Pretty Lake Avenue, Norfolk, Virginia 23518, the address of record on file with the Board of Nursing. On April 21, 2015, Mr. Hinnant was granted a continuance and the informal conference was rescheduled for June 8, 2015.

3. During the course of his employment with Golden Living Center, Portsmouth, Virginia, on August 7, 2014, Mr. Hinnant administered two units of insulin to the wrong resident and failed to immediately notify the resident's physician, his supervisor, or the patient's family.

4. During the course of his employment with Lake Taylor Transitional Care Hospital ("Lake Taylor"), Norfolk, Virginia:

a. On January 16, 2014, Mr. Hinnant informed his Director of Nursing ("DON") and the Nurse Manager that he had given medication to a patient, IV; however, he had not actually given the medication and he had not informed the patient's physician of the missed medication.

b. Between August 13, 2013, and August 26, 2013, Mr. Hinnant failed to administer the correct dose of ampicillin to a patient and he failed to inform the DON or the Nurse Manager until the following day.

c. On August 13, 2013, Mr. Hinnant administered an incorrect dose of morphine to a resident.

5. During the course of his employment with Autumn Care of Norfolk, Norfolk, Virginia:

a. On October 12, 2012, Mr. Hinnant failed to document a resident's admission and ensure an admission assessment was completed on the resident in a timely manner.

b. Between September 26, 2012 and September 28, 2012, Mr. Hinnant failed to correctly document new physician's orders and failed to discontinue orders as directed.

c. On July 19, 2012, Mr. Hinnant failed to administer Augmentin to a resident, as ordered, and he incorrectly documented the physician's order regarding Percocet.

6. On July 15, 2014, during an interview with a Virginia Department of Health Professions' investigator, Mr. Hinnant was asked to submit to a urine drug screen; he tested positive for opiates, codeine, morphine, and tramadol. The positive results were due to his prescribed medications for pain.

7. Mr. Hinnant is currently prescribed acetaminophen/codeine (Tylenol #4), tramadol and Neurontin for pain and sciatica.

8. On May 21, 2014, during Lake Taylor's investigation, Mr. Hinnant tested positive for marijuana and opiates on a urine drug screen.

9. On October 28, 2009, Mr. Hinnant was convicted of one count of misdemeanor driving under the influence of alcohol in the Portsmouth, Virginia, General District Court.

10. Mr. Hinnant has had five employers over the last five years, with two terminations. Mr. Hinnant was terminated from Golden Living Center for unsafe nursing practices, and from Lake Taylor for the positive drug screen.

11. Mr. Hinnant provided evidence that he took another drug screen on May 21, 2014, following his termination from Lake Taylor, which was negative for all substances other than his prescribed medications.

12. Mr. Hinnant stated that he has been employed with DaVita Dialysis since February 2015. He stated that he likes working at the dialysis facility because it is less stressful and he gets to work with one client at a time.

### CONCLUSIONS OF LAW

Findings of Fact Nos. 3, 4 and 5 constitute a violation of 54.1-3007(2), (5), and (8) of the Code and 18 VAC 90-20-300(A)(2)(f) of the Regulations Governing the Practice of Nursing.

### ORDER

On the basis of the foregoing, the Committee hereby ORDERS as follows:

1. Tuck Hinnant, R.N., is hereby REPRIMANDED.
2. Mr. Hinnant shall provide the Board with verification that he has completed the following NCSBN online courses: "*Professional Accountability & Legal Liability for Nurses*"; "*Medication Errors: Detection & Prevention*"; and "*Sharpening Critical Thinking Skills*", within 90 days of the date this Order is

entered. These courses shall not be credited toward the continued competency requirements for the next renewal of her license.

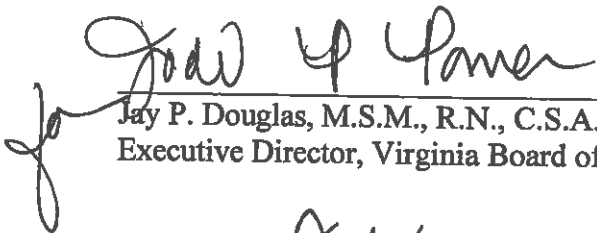
3. Mr. Hinnant shall maintain a course of conduct in his capacity as a professional nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

4. Any violation of the terms and conditions of this Order or of any law or regulation affecting the practice of nursing in the Commonwealth of Virginia shall constitute grounds for the suspension or revocation of the license of Mr. Hinnant and an administrative proceeding shall be convened to determine whether such license shall be suspended or revoked.

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.

Pursuant to Section 54.1-2400(10) of the Code, Mr. Hinnant may, not later than 5:00 p.m., on August 4, 2015, 2015, notify Jay P. Douglas, M.S.M., R.N., C.S.A.C., F.R.E., Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

FOR THE COMMITTEE:

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

ENTERED: July 2, 2016

Certified True Copy

By   
Virginia Board of Nursing

This Order shall become final on August 4, 2015, unless a request for a formal administrative hearing is received as described above.