VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: JACQUELYN GOODE, L.P.N.
License No.: 0002-090884

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 August 5, 2015 in Henrico County, Virginia, to inquire into evidence that Jacquelyn Goode, L.P.N., may have violated certain laws and regulations governing nursing practice in Virginia. Ms. Goode was not present and was not represented by counsel.

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

FINDINGS OF FACT

1. Jacquelyn Goode, L.P.N., was issued License No. 0002-090884 to practice practical nursing in the Commonwealth of Virginia on June 13, 2014. Said license is set to expire on August 31, 2015. Ms. Goode's primary state of residence is Virginia. Ms. Goode also held licenses to practice practical nursing in Colorado and the District of Columbia, both of which are expired.

2. By letter dated July 6, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Goode notifying her that an informal conference would be held on August 5, 2015. The Notice was sent by certified and first class mail to 589 Verge Street, Clifton Forge, Virginia, 24422, the address of record on file with the Board of Nursing. The Notice sent by certified mail was signed for by Talmadge Goode on July 8, 2015. The Notice sent by first class mail was not returned to the Board office. The Committee

Chair concluded that adequate notice was provided to Ms. Goode and the informal conference proceeded in her absence.

3. During the course of her employment with Golden Living Center Alleghany, Clifton Forge, Virginia:

a. On October 20, 2014, by her own admission, Ms. Goode failed to give Resident A her midnight dose of Ativan (lorazepam, C-IV). Ms. Goode then administered two doses of Ativan to Resident A at 3:30 a.m. Ms. Goode falsely documented on the resident's electronic medication administration record ("EMAR") that she had administered the medication at 12:00 a.m. and at 4:00 a.m. In addition, Ms. Goode failed to notify the resident's physician of the medication error and failed to receive approval from the physician prior to administering the medication against physician orders.

b. On September 28, 2014, Ms. Goode signed out one tablet of Ativan at approximately 9:05 p.m. for Resident B, but another nurse had already signed out the same medication at approximately 8:30 p.m. and documented the administration of the medication on the resident's EMAR. Ms. Goode failed to document the administration of the medication and/or wastage of the medication, thereby leaving one tablet of Ativan unaccounted for.

c. On October 10, 2014 and October 19, 2014, Ms. Goode signed out one tablet of Ambien (zolpidem, C-IV) for Resident C, but on each occasion she failed to document the medication administration on the resident's EMAR and/or wastage of the medication, thereby leaving two tablets unaccounted for.

4. On February 12, 2015, during an interview with an investigator for the Virginia Department of Health Professions ("DHP"), Ms. Goode stated that electronic documentation was a new process for her and that she failed to document medication administration on the patients' EMAR's. With regard to the incident with Resident A, Ms. Goode stated that she had fallen behind while conducting her medication pass

and when she got to Resident A she administered the missed dose as well as the current dose at the same time.

5. Golden Living Center requested that Ms. Goode submit to a urine drug screen on October 23, 2014; the urine drug screen was negative for all substances tested. Ms. Goode's employer reported that Ms. Goode never showed signs or symptoms of impairment.

6. Ms. Goode's employment with Golden Living Center was terminated at the end of October 2014, after a six-month term of employment.

CONCLUSIONS OF LAW

1. Finding of Fact No. 3(a) constitutes a violation of §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(a), (e) and (f) of the Regulations Governing the Practice of Nursing ("Regulations").

2. Finding of Fact No. 3(b) constitutes a violation of §54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(e) and (f) of the Regulations.

3. Finding of Fact No. 3(c) constitutes 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.

ORDER

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

1. Jacquelyn Goode, L.P.N., is hereby REPRIMANDED.

2. Ms. Goode shall maintain a course of conduct in her capacity as a licensed practical 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.

Pursuant to Section 54.1-2400(10) of the Code, Ms. Goode may, not later than 5:00 p.m., on September 16, 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 she 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:

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

ENTERED: August 14th, 2015

This Order shall become final on September 16, 2015; unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By _____
Virginia Board of Nursing