VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: SUSANNAH ARNOLD, R.N.
License No.: 0001-213851

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 May 28, 2015 in Henrico County, Virginia. Ms. Arnold was not present nor was she represented by legal counsel. Allison Gregory, M.S., R.N., F.N.P.-B.C., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On July 15, 2105, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Arnold 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. Susannah Arnold, R.N., was issued License No. 0001-213851 to practice professional nursing in Virginia on July 9, 2008. Said license expired on April 30, 2015. Ms. Arnold's primary state of residence is Virginia.

2. By letter dated April 24, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Arnold notifying her that an informal conference would be held on May 27, 2015. The Notice was sent by certified and first class mail to 241 Boxwood Street, Glade Spring, Virginia, 24340, the address of record on file with the Board of Nursing. The Notice sent by certified mail was returned to the Board office marked "undeliverable as addressed, unable to forward." The first class mail was

returned to the Board office marked "forward time expired, return to sender." The Agency Subordinate concluded that adequate notice was provided to Ms. Arnold and the informal conference proceeded in her absence.

3. During the course of her employment with NHC Healthcare of Bristol, Bristol, Virginia ("NHC Healthcare"), Ms. Arnold diverted medications, including narcotics and controlled substances, and falsely documented medication administration, as evidenced by the following:

a. On November 20, 2014, Ms. Arnold documented on Patient A's Medication Administration Record ("MAR") that she administered medications, including controlled substances and narcotics, at approximately 9:00 p.m. However, the patient's medications were not delivered from the pharmacy until approximately 9:50 p.m. that night. Furthermore, the alert and oriented patient stated that he did not receive any medications until November 21, 2014 at 3:00 a.m., and that he refused one of the medications documented as being administered.

b. On November 21, 2014, Ms. Arnold documented on Patient A's Narcotic Inventory Record, that she administered Oxycodone IR (C-II) at 1:00 a.m.; however, she documented on the patient's MAR that she administered the medication at 12:00 a.m. Furthermore, the patient stated that he did not receive any medications until November 21, 2014 at 3:00 a.m.

c. November 22, 2014, Ms. Arnold documented on Patient B's MAR that she administered Lortab (hydrocodone-acetaminophen, C-II), one tablet every four hours as needed for pain, at 5:52 a.m.; however, she documented on the Narcotic Inventory Record that she administered the medication at 5:00 a.m. In addition, Ms. Arnold failed to follow facility protocol and documented that she had administered the medication without scanning the medication and failed to give any explanation regarding the deviation from protocol. When a co-worker took over Ms. Arnold's assignment at approximately 8:00 a.m., the patient, whose pain was normally well controlled with

prescribed pain medication, was crying out in pain.

d. On November 22, 2014, Ms. Arnold documented on Patient C's MAR that she administered oxycodone IR (C-II), one tablet every eight hours as needed for pain, at 4:22 a.m. and she made a note that she actually administered the medication at 1:00 a.m. However, Ms. Arnold documented on the PRN Administration Report that she administered the medication at 2:00 a.m. Furthermore, Ms. Arnold failed to follow facility protocol in that she documented that she had administered the medication without scanning the medication and without any explanation given for doing so. When a co-worker took over her assignment at approximately 8:00 a.m. the patient, whose pain was normally well controlled with prescribed pain medication was crying out in pain.

4. During the course of her employment with NHC Healthcare, coworkers became alarmed by Ms. Arnold's actions and reported concerns about whether she was safe to practice nursing, due to the following: between September 16, 2014 and November 24, 2014, Ms. Arnold exhibited drug-seeking behavior in that, on a daily basis, she repeatedly asked the medication nurses for their keys to the medication carts and repeatedly asked to pass medications. Ms. Arnold would become upset if she was not assigned to pass medications and requested that other staff allow her to pass medications for them.

5. On November 6, 2014, Ms. Arnold tested positive for opiates and amphetamine on a urine drug screen. She was asked to provide the facility with recent prescriptions to justify the results but she failed to do so.

6. Ms. Arnold's employment with NHC Healthcare was terminated on November 24, 2014, for multiple discrepancies with medications, narcotics and documentation.

7. During the course of her employment with Maxim Healthcare Services, Abingdon, Virginia, on March 1, 2014, Ms. Arnold diverted approximately 22 tablets of Klonopin (clonazapam,

C-IV) from Patient E for her own personal and/or unauthorized use.

8. Ms. Arnold's employment with Maxim Healthcare Services was suspended on March 1, 2014, pending investigation. The suspension was lifted on March 14, 2014, but Ms. Arnold never returned to work and was subsequently terminated.

9. During the course of her employment with American Home Care, Abingdon, Virginia, on two occasions, between April 2014 and May 2014, Ms. Arnold diverted over 20 tablets of Percocet (oxycodone, C-II) from Patient F for her own personal and/or unauthorized use.

10. Ms. Arnold resigned from American Home Care on August 18, 2014, by text message and without notice.

11. On her application for employment with NHC Healthcare, dated September 16, 2014, Ms. Arnold falsely indicated that her reason for leaving Blue Ridge Job Corps, Marion, Virginia, was because of favoritism in the workplace. However, her employment as a Career Technical Instructor was terminated on September 20, 2013, for allowing unqualified C.N.A. students to perform clinical rotations.

12. On her application for employment with American Home Care, dated March 17, 2014, Ms. Arnold falsely indicated that her reason for leaving Blue Ridge Job Corps was because of favoritism and an inability to advance and practice her licensed skills. However, her employment was terminated on September 20, 2013.

13. On her application for employment with Maxim Healthcare Services, dated October 3, 2013, Ms. Arnold falsely indicated that her reason for leaving Blue Ridge Job Corps was because of "lack of nursing skill." However, her employment was terminated on September 20, 2013.

14. An investigator with the Virginia Department of Health Professions made numerous attempts to contact Ms. Arnold by phone, email and the United States Postal Service. Ms. Arnold

failed to respond to any of the investigator's attempts.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 3(a), (b), (c) and (d) constitute a violation of §54.1-3007(2), (3), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c), (e), (f) and (k) of the Regulations Governing the Practice of Nursing ("Regulations").

2. Findings of Fact Nos. 4 and 5 constitute a violation of §54.1-3007(6) of the Code.

3. Findings of Fact Nos. 7 and 9 constitute a violation of §54.1-3007(2), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c), (f) and (k) of the Regulations.

3. Findings of Fact Nos. 11, 12 and 13 constitute a violation of §54.1-3007(2) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Regulations.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. The right of Susannah Arnold, R.N., to renew License No. 0001-213851 to practice professional nursing in the Commonwealth of Virginia is hereby INDEFINITELY SUSPENDED.

2. The license will be recorded as suspended.

3. At such time as Ms. Arnold shall petition the Board for reinstatement of her license, an administrative proceeding will be convened to determine whether she is capable of resuming the safe and competent practice of professional nursing. Ms. Arnold 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.

4. This suspension applies to any multistate privilege to practice professional 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. Arnold failed to appear at the informal conference, this Order shall be considered final. Ms. Arnold 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. Arnold has thirty (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

Gloria Mitchell-Lively

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

Entered: July 24, 2015

Certified True Copy
By
Virginia Board of Nursing