VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: JESSICA GOODMAN, L.P.N.
License No.: 0002-084798

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 27, 2015 in Henrico County, Virginia. Ms. Goodman was present and was not 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, 2015, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Goodman Ms. Goodman 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. Jessica Goodman, L.P.N., was issued License No. 0002-084798 to practice practical nursing in Virginia on May 13, 2011. Said license expired on January 31, 2015. Ms. Goodman'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. Goodman notifying her that an informal conference would be held on May 27, 2015. The Notice was sent by certified and first class mail to 220 Shiloh Park, Hampton, Virginia, 23669, the address of record on file with the Board of Nursing.

3. During the course of her employment with Virginia Health Services, while employed at Coliseum Convalescent & Rehabilitation, Hampton, Virginia:

a. On August 19, 2014, Ms. Goodman attempted to administer medication to Resident A by repeatedly forcing a spoon against the resident's mouth.

b. On August 19, 2014, by her own admission to a Virginia Department of Health Professions ("DHP") investigator, Ms. Goodman administered Lortab (hydrocodone-acetaminophen, C-II) to Resident B two hours prior to the scheduled time of administration.

c. On August 20, 2014, by her own admission, Ms. Goodman administered Ativan (lorazepam, C-IV) to Resident C after the order was discontinued by the resident's physician on August 13, 2014. At the informal conference, Ms. Goodman stated that the facility was transitioning from paper MAR's to electronic MAR's and this particular order had not been updated on the Controlled Substance Form. She further stated that this was due to other nurses failing to transcribe orders. She admitted she failed to verify the order in the electronic MAR prior to administering the medication.

d. On August 20, 2014, by her own admission, Ms. Goodman began the evening medication pass over an hour late and failed to timely check residents' blood sugars prior to their evening meal. At the informal conference, Ms. Goodman stated that she was running behind due to the needs of a newly admitted patient.

4. During the course of her employment with Virginia Health Services, while employed at James River Convalescent Center, Newport News, Virginia, between May 2012 and November 2013, Ms. Goodman was counseled in writing and/or verbally approximately five times regarding medication administration, verification of medication orders and/or documentation of medication administration as evidenced by the following:

a. On November 13, 2013, Ms. Goodman failed to administer UTI STAT as ordered

and failed to document the administration on the resident's medication administration record ("MAR").

b. On October 9, 2013, Ms. Goodman failed to accurately verify a new medication order for a resident and failed to transcribe the order in to the resident's MAR.

c. On May 29, 2013, and May 30, 2013, Ms. Goodman failed to accurately verify a new medication order and failed to administer Oscal to a resident as ordered.

d. On September 1, 2012, September 2, 2012, September 12, 2012 and September 21, 2012, Ms. Goodman failed to administer Pepcid to a resident as ordered by the resident's physician and failed to accurately document the medication administration on the resident's MAR.

e. On May 2, 2012, Ms. Goodman failed to accurately verify new medication orders for two residents.

5. At the informal conference, Ms. Goodman admitted that physician orders were not always transcribed during her employment at James River Convalescent Center and rationalized this by stating she was having to work two units and was responsible for approximately 60 to 70 patients. Ms. Goodman stated that she did not receive help from other nurses and that she had contacted the administration with her concerns numerous times; Ms. Goodman failed to provide any evidence of her contact with administration.

6. During the course of her employment with Virginia Health Systems, Coliseum Convalescent & Rehabilitation, Hampton, Virginia, between May 6, 2014 and August 20, 2014, by her own admission, Ms. Goodman repeatedly failed to follow proper procedures regarding medication wastages, including failing to have her wastages witnessed by a co-worker, as evidenced by the following:

a. On August 20, 2014, by her own admission to a DHP investigator and the facility, Ms. Goodman wasted oxycodone (C-II) and Ativan without a witness.

b. On January 26, 2015, during an interview with a DHP investigator, Ms. Goodman

stated that she wasted narcotics three or four times previously without a witness. At the informal conference, Ms. Goodman stated she asked other nurses to witness her wastages but they often told her they did not have time. In addition, Ms. Goodman stated that at times there was no one else available to witness the waste as she was the only nurse with the ability to witness a wasted medication on duty.

7. Ms. Goodman's employment with Virginia Health Services was terminated on August 20, 2014.

8. At the informal conference, Ms. Goodman stated that following her termination from Virginia Health Services she was employed by Serenity Home Care for approximately one month, but was terminated due to absenteeism.

9. By her own admission to a DHP investigator, Ms. Goodman stated that she has used marijuana since she was 14 years old, and that she currently smokes "maybe a blunt's worth a day." At the informal conference, Ms. Goodman stated that she last used marijuana "a few weeks ago".

10. By her own admission, Ms. Goodman currently suffers from depression, anxiety and panic attacks. In addition, she was admitted to Maryview Behavioral Health Center, Portsmouth, Virginia, on August 13, 2009, following a suicide attempt.

11. At the informal conference, Ms. Goodman stated that she currently sees Ashley Garcia, L.N.P., at Associates of York, every three months for medication management; she is currently prescribed Celexa, Buspar, Remeron and Klonopin. A therapist at Associates of York stated to the DHP investigator that Ms. Goodman's prognosis was poor and she failed to follow through with treatment. At the informal conference, Ms. Goodman verified that she is not attending mental health or substance abuse counseling despite recommendations from Ms. Garcia to do so.

12. On January 26, 2015, a DHP investigator asked Ms. Goodman to submit to a urine drug screen by the end of the day. Ms. Goodman failed to submit a sample until February 5, 2015. The sample

was positive for benzodiazepines (clonazepam) and cannabinoids (THC).

13. Ms. Goodman stated that she is aware of the Health Practitioners' Monitoring Program but that she has not entered the program due to financial and transportation reasons.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 3(a), (b), (c) and (d) and 4 (a), (b), (c), (d) and (e) 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.

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

3. Findings of Fact Nos. 9, 10 and 12 constitute a violation of §54.1-3007(6) of the Code.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. The right of Jessica Goodman, L.P.N., to renew License No. 0002-084798 to practice practical nursing in the Commonwealth of Virginia is hereby INDEFINITELY SUSPENDED.

2. The license will be recorded as suspended.

3. At such time as Ms. Goodman 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 practical nursing. Ms. Goodman 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 practical nursing.

5. This suspension shall be STAYED upon proof of entry into the HPMP and compliance with a Recovery Monitoring Contract with the Health Practitioners' Monitoring Program ("HPMP") pursuant to Chapter 25.1 of Title 54.1 of the Code and 18 VAC 76-10-10 *et seq.* of the Regulations

Governing the HPMP. At such time, the indefinite suspension shall be STAYED and the following terms and conditions shall apply:

a. Ms. Goodman shall comply with all terms and conditions for the period specified by the HPMP.

b. Any violation of the terms and conditions stated in this Order shall be reason for summarily rescinding the stay of indefinite suspension of the license of Ms. Goodman, and an administrative proceeding shall be held to determine whether her license shall be revoked. The stay of indefinite suspension may be summarily rescinded at such time the Board is notified that:

i. Ms. Goodman is not in compliance with the terms and conditions specified by the HPMP;

ii. Ms. Goodman's participation in the HPMP has been terminated;

iii. There is a pending investigation or unresolved allegation against Ms. Goodman involving a violation of law, regulation, or any term or condition of this order.

6. Upon receipt of evidence of Ms. Goodman's participation and successful completion of the HPMP, the Board, at its discretion, may waive Ms. Goodman's appearance before a Committee and conduct an administrative review of this matter, at which time she may be issued an unrestricted license.

7. This Order is applicable to Ms. Goodman's multistate licensure privileges, if any, to practice practical nursing. For the duration of this Order, Ms. Goodman shall not work outside of the Commonwealth of Virginia pursuant to a multistate licensure privilege without the written permission of the Virginia Board of Nursing and the Board of Nursing in the party state where she wishes to work. Any requests for out of state employment should be directed, in writing, to the Executive Director of the Board.

8. Ms. Goodman shall maintain a course of conduct in her capacity as a practical nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.

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.

Pursuant to Section 54.1-2400(10) of the Code, Ms. Goodman may, not later than 5:00 p.m., on August 26, 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 BOARD:

Gloria Mitchell-Lindy

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

This Order shall become final on August 26, 2015, unless a request for a formal administrative hearing is received as described above.

Certified True Copy
By _____
Virginia Board of Nursing