VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: CHERIE HUFFMAN, L.P.N.
License No.: 0002-076120

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 February 18, 2015 in Henrico County, Virginia. Ms. Huffman was not present nor was she represented by legal counsel. Jane Elliott, R.N., Ph.D., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On March 25, 2015, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Huffman 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. Cherie Huffman, L.P.N., was issued License No. 0002-076120 to practice practical nursing in Virginia on June 29, 2007. Said license is set to expire on April 30, 2016. Ms. Huffman's primary state of residence is Virginia.

2. By letter dated January 12, 2015, the Board of Nursing ("Board") sent a Notice of Informal Conference ("Notice") to Ms. Huffman notifying her that an informal conference would be held on February 18, 2015. The Notice was sent by certified and first class mail to 64 Cedar Ridge Dive, Daleville, Virginia, 24083, the address of record on file with the Board. The notice sent by certified mail

was delivered on January 20, 2015; the first class mail was not returned to the Board office. An Amended Notice was sent by overnight mail on February 12, 2015, and was delivered on February 13, 2015. The Agency Subordinate concluded that adequate notice was provided to Ms. Huffman and the informal conference proceeded in her absence.

3. During the course of her employment with Avante at Roanoke, Roanoke, Virginia:

a. On June 3, 2014, Ms. Huffman failed to correctly document receipt of a physician's order on a lab results sheet to hold Resident A's Coumadin and to have new PT/INR laboratory tests completed on June 5, 2014. Ms. Huffman placed the information in the order field of the Medication Administration Record ("MAR") and did not place an actual hold on the medication. The resident continued to receive Coumadin until June 14, 2014, when the error was noticed. On June 14, 2014, PT/INR results were immediately ordered and the resident was hospitalized for several days due to critical PT/INR results.

b. On July 1, 2014, Ms. Huffman failed to correctly document receipt of a physician's order to continue Resident B's Coumadin and have new PT/INR laboratory tests completed on July 10, 2014. Ms. Huffman documented the verbal order on a laboratory sheet for the tests to be completed on July 13, 2014, and she did not place a medication order for Coumadin in the MAR. Resident B stopped receiving his Coumadin on July 10, 2014, and the medication was restarted on July 12, 2014. Resident B did not suffer any harm; however, the documentation error resulted in an interruption of the continuity of care for the resident. Ms. Huffman acknowledged to an investigator for the Department of Health Professions ("DHP") that she had placed the wrong date in the computer for the laboratory tests.

c. On July 10, 2014, Ms. Huffman failed to complete skin assessments on five residents. Ms. Huffman indicated that she did not have any independent memory of missing the skin assessments but she acknowledged that she may not have completed them. On November 12, 2014,

during an interview with a DHP investigator, Ms. Huffman acknowledged that she had previously been counseled about the importance of documenting skin assessments.

4. On July 10, 2014, Ms. Huffman falsely documented that she had applied a Fentanyl patch to Resident C. Ms. Huffman had not applied the patch nor removed the patch from the resident's medications. Additionally, on the location of administration report, Ms. Huffman documented two events at 9:04 a.m. on July 10, 2014; however, she documented one administration site as the abdomen and one administration site as the chest. The next scheduled patch change was July 13, 2014, at which time the discrepancy was found. Ms. Huffman indicated to the DHP investigator that she had checked the wrong box on the MAR and she should have indicated that the resident refused the patch.

5. On July 10, 2014 and July 11, 2014, Ms. Huffman falsely documented that she had checked the placement of Resident C's Fentanyl patch. As noted in Finding of Fact No. 4, the new patch was never placed on Resident C, and this error was not discovered until July 13, 2013.

6. Ms. Huffman's employment with Avante at Roanoke was terminated on July 21, 2014, due to false documentation.

7. Ms. Huffman was employed with The Hermitage, Roanoke, Virginia, from April, 2013, to February 15, 2014. On February 15, 2014, Ms. Huffman's employment was terminated for medication transcription errors as well as her being a "no call/no show." She is not eligible for re-hire. Employment records indicated that the medication transcription errors that resulted in her termination constituted her fourth violation of the facility's medication management policy since December 2013. Furthermore, Ms. Huffman informed the facility that she was a "no call/no show" because she was in a local jail for a drunk in public charge. Ms. Huffman was subsequently convicted of misdemeanor drunk in public on March 18, 2014, in the Roanoke City, Virginia, General District Court, and was issued a $25.00 fine.

8. Prior to being employed with The Hermitage, Ms. Huffman was terminated from Carilion

Clinic-Brambleton Office, Roanoke, Virginia, due to having accessed medical records of patients for personal reasons. By Board Order entered February 7, 2014, Ms. Huffman received a reprimand based on this incident.

CONCLUSIONS OF LAW

1. Finding of Fact No. 3(a), (b) and (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 Governing the Practice of Nursing.

2. Findings of Fact Nos. 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)(e) and (f) of the Regulations.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. License No. 0002-076120 of Cherie Huffman, L.P.N., is INDEFINITELY SUSPENDED.

2. The license will be recorded as suspended and no longer current.

3. At such time as Ms. Huffman 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 nursing. Ms. Huffman 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.

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. Huffman failed to appear at the informal conference, this Order shall be considered

final. Ms. Huffman 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. Huffman 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

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

Entered: April 10, 2015

Certified True Copy

By _____
Virginia Board of Nursing