VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: **NICOLE STATON, R.N.**
License No.: 0001-225944

ORDER

Pursuant to §§ 2.2-4020, 54.1-110 and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was held before a panel of the Board of Nursing ("Board") on January 29, 2015, in Henrico County, Virginia, to inquire into evidence that Ms. Staton may have violated certain laws and regulations governing nursing practice in Virginia. The case was presented by Wendy Deaner, Adjudication Specialist, Administrative Proceedings Division. Charis Mitchell, Assistant Attorney General, was present as legal counsel for the Board. Ms. Staton was not present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Nicole Staton, R.N., was issued License No. 0001-225944 to practice as a professional nurse in the Commonwealth of Virginia on July 14, 2010. Said license is set to expire on October 31, 2016. Ms. Staton also holds License No. 0117-006011 issued by the Virginia Board of Medicine to practice as a respiratory care practitioner in the Commonwealth of Virginia. Ms. Staton's primary state of residence is Virginia.

2. Based upon the representations of Wendy Deaner, Adjudication Specialist, and Commonwealth's Exhibit #1, the Notice of Formal Hearing and Affidavit of Mailing, the presiding officer ruled that adequate notice was provided to the respondent and the hearing proceeded in her absence.

3. During the course of her employment with Lewis Gale Medical Center, Salem, Virginia,

during the months of February and March 2014, Ms. Staton diverted narcotic medication for her personal and/or other unauthorized use and falsified patient records, as evidenced by the following:

a. On March 27, 2014, during an investigation by the facility following a pharmacy audit, facility security officers searched Ms. Staton's purse. In her purse, security found approximately 40 small baggie corners containing a white residue, two bottles of medication appearing to be a mixture of medications and a prescription bottle bearing her name for Percocet (oxycodone, Schedule II). In her possession she also had individually wrapped pills which she indicated were Tylenol from patients at Golden Living Center-Alleghany, Clifton Forge, Virginia, who did not want their pills. Lastly, a package of at least ten syringes, without needles, was found during the search.

b. On March 12, 2014 and March 13, 2014, Ms. Staton documented administering morphine sulfate 4 mg IV (Schedule II) and Percocet 5/325 (oxycodone hcl/acetaminophen 5/325, Schedule II) to Patient 1 against physician orders. Physician's orders indicated Percocet 5/325 was to be given two tablets every four hours as needed for severe pain with a score of 8 to 10 on the pain scale. Morphine sulfate 4 mg, IV, was to be given every three hours for severe pain with a score of 8 to 10 on the pain scale, if unable to tolerate oral medication. Patient 1 indicated her pain was 6 out of 10 on the pain scale and Ms. Staton documented administering both medications at approximately the same time on three occasions. Patient 1's physician reviewed the medication administration record ("MAR") and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it would have likely caused harm to the patient.

c. On March 12, 2014 and March 13, 2014, Ms. Staton documented administering Percocet 5/325, Dilaudid 2 mg (hydromorphone, Schedule II,) and morphine sulfate 4 mg to Patient 2 against physician orders. Physician's orders indicated that Percocet 5/325 was to be given two tablets, by mouth, every three hours as needed for severe pain with a score of 8 to 10 on the pain scale. Morphine sulfate 4 mg, IM, was to be given every four hours as needed for breakthrough pain. Dilaudid 2 mg was to be given by

mouth, every four hours as needed for breakthrough pain. Ms. Staton documented administering Percocet 5/325 and Dilaudid 2mg to Patient 2 at approximately the same time on three occasions. She also documented administering Dilaudid 2 mg at approximately the same time as morphine sulfate 4 mg and Percocet 5/325 on March 12, 2014. Patient 2 indicated her pain ranged from 5 to 7 on the pain scale on March 12, 2014 and Ms. Staton failed to assess a pain level on March 13, 2014. Patient 2's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it could have resulted in injury to the patient.

d. On March 12, 2014 and March 13, 2014 Ms. Staton administered Percocet 5/325 to Patient 3 against physician orders. The physician order indicated Percocet 5/325 was to be given one tablet, by mouth, every three hours as needed for severe pain, an 8 to 10 on the pain scale. On three occasions Ms. Staton documented administering Percocet to Patient 3 when she indicated her pain was a 5 on the pain scale. Patient 3's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it could have resulted in injury to the patient.

e. On March 19, 2014 and March 20, 2014 Ms. Staton administered morphine sulfate 2 mg and Vicodin 5/325 (hydrocodone bit/acetaminophen 5/325, Schedule III) against physician orders to Patient 4. Physician orders indicated Vicodin 5/325 was to be given two tablets, by mouth, every four hours as needed for severe pain. Morphine sulfate 2 mg, IV, was to be given every hour as needed for severe pain, if unable to take oral medication. On March 19, 2014 at 8:07 p.m. Ms. Staton documented administering two tablets of Vicodin 5/325 to Patient 4. At approximately 9:30 p.m. she documented administering morphine sulfate 2 mg to Patient 4. At 11:57 p.m. she documented administering both morphine sulfate 2 mg and Vicodin 5/325 to Patient 4. On March 20, 2014 Ms. Staton documented administering morphine sulfate 2 mg at 1:39 a.m. and at 4:24 a.m. she documented administering both morphine sulfate and Vicodin 5/325 to Patient 4. Patient 4's physician reviewed the MAR and indicated that the administration was in violation of

his order and that if the medications were administered as indicated on the MAR it could have resulted in injury to the patient.

f. From March 20, 2014 to March 22, 2014 Ms. Staton administered OXY-IR 5 mg (Oxycodone HCL, Schedule II), to Patient 5 against physician's orders. Physician's orders indicated Patient 5 was to receive one tablet every eight hours as needed for pain after trying Tylenol first. On March 20, 2014, on two occasions Ms. Staton documented administering Tylenol at the same time she documented administering OXY-IR. On March 21, 2014 on two occasions she administered Tylenol at the same time as OXY-IR. On March 22, 2014 Ms. Staton gave OXY-IR and Tylenol at approximately the same time. Patient 5's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it could have resulted in injury to the patient.

g. From March 25, 2014 to March 27, 2014 Ms. Staton administered Percocet 5/325 to Patient 6 against physician orders. Physician orders indicated Percocet 5/325 was to be given two tablets, every four hours as needed for severe pain, an 8 to 10 on the pain scale. On four occasions Ms. Staton documented administering Percocet 5/325 to Patient 6 when he indicated his pain was a 4 or a 5 on the pain scale. On one occasion she administered Percocet 5/325 to Patient 6 an hour early and he indicated his pain was only a 4 on the pain scale. Patient 6's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it could have resulted in injury to the patient.

h. On March 26, 2014 and March 27, 2014 Ms. Staton administered Lortab 7.5/325 mg (hydrocodone/acetaminophen, Schedule III) and morphine sulfate 2 mg IV to Patient 7 against physician orders. Physician orders indicated Lortab 7.5/325 was to be given one tablet every four hours as needed for moderate pain, 4 to 7 on the pain scale. Morphine sulfate 2 mg, IV, was to be given every three hours as needed for moderate pain, 4 to 7 on the pain scale, if unable to take oral medication. On three occasions Ms. Staton documented administering both Lortab 7.5/325 and morphine sulfate 2 mg to Patient 7 at

approximately the same time. Patient 7's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it would have likely caused harm to the patient.

i. On February 26, 2014 and February 27, 2014 Ms. Staton administered Lortab 10/325 and Dilaudid 2 mg, IV, to Patient 8, against physician orders. Physician orders indicated Lortab 10/325 was to be given one tablet, by mouth, every four hours as needed for moderate pain. Dilaudid 2 mg, IV, was to be given every 30 minutes as needed for severe pain with a maximum of 4 mg/4 hours. On February 26, 2014, Ms. Staton documented administering Lortab 10/325 at the same time as Dilaudid 2 mg to Patient 8 at approximately 8:34 p.m. and 11:53 p.m. On February 27, 2014 she documented administering Dilaudid 2 mg to Patient 8 at approximately 1:16 a.m. and 2:52 a.m. On February 27, 2014 at 5:47 a.m. she documented administering Dilaudid 2 mg at approximately the same time as Lortab. Patient 8's physician reviewed the MAR and indicated that the administration was in violation of his order and that if the medications were administered as indicated on the MAR it would have likely caused harm to the patient.

j. On February 28, 2014 Ms. Staton documented administering Dilaudid 0.5 mg, IV, and Percocet 5/325 to Patient 9 against physician orders. The physician's orders indicated that Percocet was to be administered two tablets every four hours as needed for severe pain. Dilaudid 0.5 mg, IV, was to be given every hour as needed for severe pain. At approximately 10:51 p.m. Ms. Staton pulled both medications but only documented administering the Percocet. At approximately 2:45 a.m. and 6:17 a.m. she documented administering Percocet and Dilaudid to Patient 9 at approximately the same time.

k. On February 28, 2014 and March 1, 2014 Ms. Staton documented administering morphine sulfate 8mg, IV, and Dilaudid 4 mg to Patient 10 against physician orders. Morphine sulfate was to be administered, IV, every four hours as needed, with a pain indication of 9 to 10 on the pain scale. Dilaudid was to be administered one tablet, by mouth, every six hours as needed for pain. On March 1, 2014 Ms. Staton documented administering both morphine sulfate and Dilaudid at approximately 1:37 a.m.

l. On February 22, 2014 Ms. Staton documented administering Percocet 5/325 to Patient 11 against physician orders. The physician orders indicated two tablets daily as needed for severe pain, a 7 or above on the pain scale. Ms. Staton documented administering two tablets to Patient 11 three times on February 22, 2014 between the hours of 12:00 a.m. and 7:00 a.m.

m. On February 26, 2014 and February 27, 2014 Ms. Staton documented administering Roxicodone 15 mg (Oxycodone HCL, Schedule II) and Dilaudid 2mg to Patient 12 against physician orders. Physician orders indicated Dilaudid was to be given two tablets every three hours as needed for pain. Oxycodone HCL 15 mg was to be administered one tablet every four hours as needed for pain. On four occasions Ms. Staton administered both medications to Patient 12 at approximately the same time.

4. Ms. Staton's employment with Lewis Gale Medical Center was terminated on April 4, 2014.

5. On April 14, 2014 Ms. Staton was admitted to Stonewall Jackson Hospital, Lexington, Virginia, pursuant to an emergency custody order.

6. Ms. Staton frequently experiences lower back pain for which she takes narcotic medications daily. She also suffers from migraines for which she takes narcotic medications.

7. An investigator with the Virginia Department of Health Professions made numerous attempts to contact Ms. Staton; however, Ms. Staton failed to respond to any of the attempts.

CONCLUSIONS OF LAW

The Board concludes that:

1. Finding of Fact No. 3 constitutes a violation of §54.1-3007 (2), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations Governing the Practice of Nursing.

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

ORDER

WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS as follows:

1. License No. 0001-225944, issued to Nicole Staton, R.N., to practice professional nursing in the Commonwealth of Virginia, is hereby REVOKED.

2. The license of Ms. Staton will be recorded as REVOKED and no longer current. Pursuant to § 54.1-2408.2 of the Code, should Ms. Staton seek reinstatement of her license after three years, she shall be responsible for any fees that may be required for the reinstatement of her license prior to issuance of her license to resume practice. The reinstatement of Ms. Staton's license shall require the affirmative vote of three-fourths of the members at a meeting of the Board.

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

4. This Order shall be applicable to Ms. Staton's multistate licensure privileges, if any, to practice professional nursing.

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.

FOR THE BOARD

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director
Virginia Board of Nursing

February 18TH, 2015
ENTERED

Certified True Copy
By dGraham
Virginia Board Of Nursing

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.