

**VIRGINIA:**

**BEFORE THE BOARD OF NURSING**

**IN RE:           CANDICE A. WINSTON, C.N.A.  
                  Certificate No.:       1401-081019**

**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 Candice A. Winston, C.N.A. may have violated certain laws and regulations governing nurse aide practice in Virginia. The case was presented by Amy E. Weiss, Adjudication Specialist, Administrative Proceedings Division. Charis Mitchell, Assistant Attorney General, was present as legal counsel for the Board. Ms. Winston 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. Candice A. Winston was issued Certificate Number 1401-081019 to practice as a nurse aide in the Commonwealth of Virginia on December 18, 1999. Said certificate expired on December 31, 2014. Candice A. Winston was issued Registration Number 0031-002729 to practice as a medication aide on March 16, 2009. Said registration expired on September 30, 2014.
2. Based upon the representations of Amy Weiss, Adjudication Specialist, and Commonwealth's Exhibit #1, the Notice of Formal Hearing, Statement of Particulars and Amended 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 Allzwell Assisted Living in Chesapeake, Virginia,

on April 7, 2014, Ms. Winston reported for her shift under the influence of mood-altering medications. Ms. Winston was sleepy and lethargic and admitted having taken Klonopin (clonazepam, Schedule IV), Xanax (alprazolam, Schedule IV), and Vicodin (hydrocodone, Schedule II) prior to coming to work.

4. On June 10, 2014, upon being hospitalized after an altercation with her boyfriend, Ms. Winston admitted that she had been drinking and that she drinks every day.

5. On August 22, 2014, on an unscheduled urine drug screen, Ms. Winston tested positive for propoxyphene (Schedule IV), for which she did not have a prescription.

6. During the course of her employment with Hills Home for Adults, Chesapeake, Virginia, on July 18-19, 2014, Ms. Winston diverted controlled substances for her personal and unauthorized use, as evidenced by the following:

a. Ms. Winston removed a tablet of Vicodin (hydrocodone, Schedule II) from Resident A's bubble pack and adulterated the pack by taping a tablet of Motrin 800 (ibuprofen) into it. Although Ms. Winston documented administering Vicodin to this resident, he complained of receiving no relief.

b. Ms. Winston wrote "expired" on Resident B's package of Phenergan (promethazine) and indicated that she had destroyed the medication, even though the expiration date was not until August 22, 2014.

c. Ms. Winston removed two tablets of Percocet (oxycodone, Schedule II) from Resident C's bubble pack and adulterated the pack by taping one ibuprofen and one Tylenol tablet in their place. In addition, Ms. Winston documented administering Percocet to Resident C but failed to actually do so.

d. Ms. Winston documented administering Vicodin to Resident D at both 8:10 p.m. and 9:48 p.m., although the resident was prescribed one Vicodin PRN every six hours.

e. Ms. Winston failed to administer Ativan (lorazepam, Schedule IV) to Resident E, but then documented administering Ativan to the resident at 8:03 p.m. In addition, Ms. Winston removed tablets of Ativan and Klonopin (clonazepam, Schedule IV) from Resident E's bubble packs and adulterated the

packs by taping other medications in their place.

f. Ms. Winston removed lorazepam from Resident F's bubble pack and adulterated the pack by taping other medications in their place.

g. Ms. Winston noted that she administered Resident G's medications but failed to actually do so.

h. Ms. Winston diverted five Motrin 800 tablets from the supply of former Resident H and substituted the medications into other residents' bubble packs to cover her diversion; at the time he was discharged several days before, Resident H had left behind a full, intact pack of the medication containing 30 tablets.

7. During the course of her employment with Hills Home for Adults, Ms. Winston refused to give her patients requested medication and treatment.

a. On July 18, 2014, Ms. Winston refused Resident E's request for Ativan.

b. In June of 2014, Ms. Winston failed to administer breathing treatment or provide a laxative to Patient G as requested.

8. On her application for employment with Hills Home, dated May 14, 2014, Ms. Winston indicated that she had left Allzwell Assisted Living due to "injury" when, in fact, her employment had been terminated on April 7, 2014, due to her impairment.

9. Two R.M.A.'s from Hills Home stated that they never taped tablets into medication packs and that taping tablets would violate Hills Home policy.

10. One of her coworkers at Hills Home testified that Ms. Winston behaved erratically, acting shaky and stressed. Ms. Winston also refused or resisted counting narcotics with the R.M.A.'s on several occasions.

11. Throughout the investigations into the above Findings of Fact, Ms. Winston denied the allegations.

### CONCLUSIONS OF LAW

The Board concludes that:

1. Findings of Fact Nos. 3-5 constitute a violation of § 54.1-3007(6) of the Code.
2. Finding of Fact No. 6 constitutes a violation of § 54.1-3007(2), (5), and (6) of the Code and 18 VAC 90-25-100(2)(c) of the Regulations Governing Certified Nurse Aides (“Regulations”).
3. Finding of Fact No. 7 constitutes a violation of § 54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-25-100(2)(e) of the Regulations.
4. Finding of Fact No. 8 constitutes a violation of § 54.1-3007(2) of the Code and 18 VAC 90-25-100(2)(d) of the Regulations.
5. Finding of Fact No. 7 and Conclusion of Law No. 3 constitute a finding of Neglect pursuant to 42 CFR § 483.156(b)(2) and (c)(1)(iv)(D) of the Code of Federal Regulations.

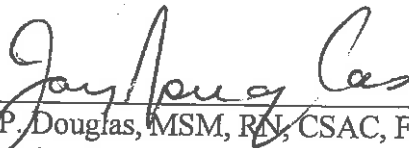
### ORDER

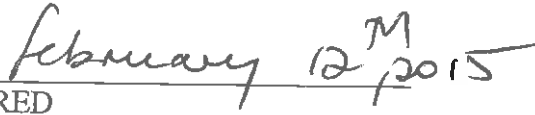
WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS as follows:

1. The right of Candice A. Winston, C.N.A. to renew Certificate No. 1401-081019 to practice as a nurse aide in the Commonwealth of Virginia is hereby REVOKED.
2. A finding of Neglect shall be ENTERED against Ms. Winston in the Virginia Nurse Aide Registry pursuant to 42 CFR § 483.13(C)(1)(ii)(B) and 42 CFR § 483.156(b)(2) and (c)(1)(iv)(D). This finding prohibits Ms. Winston’s employment as a certified nurse aide in any long-term care facility that receives Medicare or Medicaid reimbursement, according to 42 CFR § 483.13(c)(1)(ii)(B).

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

  
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ENTERED

**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.

**Certified True Copy**

By   
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Virginia Board Of Nursing