VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: PENNY G. BROWN, R.N.

CONSENT ORDER

Pursuant to §§ 2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), an informal conference was held before a Special Conference Committee ("Committee") of the Board of Nursing ("Board") on December 1, 2009, in Henrico County, Virginia, to inquire into evidence that Penny G. Brown, R.N., may have violated certain laws and regulations governing the practice of professional nursing in Virginia. Ms. Brown was present and was represented by Carolyn P. Carpenter, Esquire.

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

FINDINGS OF FACT

1. Penny Brown, R.N., was issued License No. 0001-173424 to practice professional nursing in the Commonwealth of Virginia on April 16, 2001. Said license is current and set to expire on March 31, 2010.

2. During the course of her employment with Bon Secours Regional Memorial Medical Center, Mechanicsville, Virginia:

a. Ms. Brown diverted narcotic medications for her personal and unauthorized use, as evidenced by the following:

i. On April 21, 2009, at 02:53 hours, Ms. Brown removed from Pyxis one Lortab (hydrocodone; Schedule III) for Patient A; however, she failed to document the administration, waste or

return of this medication. Ms. Brown stated that she was given a verbal order for this medication, and that she failed to document the order properly.

ii. On April 17, 2009, at 23:07 hours, Ms. Brown removed from Pyxis 15ml Lortab elixir for Patient B; however, she failed to document the administration, waste or return of the medication. Further, this patient did not have a physician's order for this medication. Ms. Brown stated that this patient had a prescription for Tylenol #3 (Schedule III) and that she mistakenly withdrew the wrong medication. She stated that she failed to appropriately document the waste of the Lortab.

iii. On April 17, 2009, at 22:10 hours and 22:56 hours, Ms. Brown removed from Pyxis a total of four Lortab tablets for Patient C and documented on the Medication Administration Record ("MAR") administering two Lortab tablets at 23:43 hours. She failed to document the administration, waste or return of the remaining two Lortab tablets. Further, this patient was unable to take medication in pill form.

iv. On April 17, 2009, at 21:45 hours, Ms. Brown removed from Pyxis one Tylenol #3 tablet for Patient B; however, she documented on the MAR administering two Tylenol #3 tablets.

v. On March 29, 2009, at 21:34 hours, Ms. Brown removed from Pyxis two Lortab tablets for Patient D; however, she failed to document the administration, waste or return of this medication. Further, this patient did not have a physician's order for this medication.

vi. On March 15, 2009, at 23:08 hours, Ms. Brown withdrew from Pyxis 15ml Lortab elixir for Patient E and documented on the MAR administering 10ml Lortab at 22:57 hours. She failed to document the administration or waste of the remaining 5ml Lortab elixir.

vii. On February 16, 2009, at 03:52 hours, Ms. Brown withdrew one Lortab tablet for Patient F; however, she failed to document the administration, waste or return of this medication. Further, this patient did not have a physician's order for this medication.

viii. On February 16, 2009, at 03:27 hours, Ms. Brown withdrew from Pyxis 1ml Lortab elixir for Patient G; however, she failed to document the administration, waste or return of this medication. Further, this patient did not have a physician's order for this medication.

viiii. On January 25, 2009, at 04:34 hours, Ms. Brown removed from Pyxis 10mg morphine sulfate (Schedule II) for Patient H and documented on the MAR administering 5mg morphine sulfate. She failed to document the administration or waste of the remaining 5mg morphine sulfate.

b. Ms. Brown acknowledged that on April 17, 2009, she left the facility with one Lortab tablet in her pocket. She stated she was unaware of what happened to the other Lortab tablets that she had withdrawn.

c. Ms. Brown stated that she erroneously withdrew medications for patients under other patient names, and failed to correct her errors in the Pyxis system. Additionally, she stated that Findings of Fact No. 2(iv) through (viii) were a result of her poor documentation of physicians' orders, and of administration or waste of medications. She denied diverting any of the medications for her personal use. She further asserted that the stress of working in the Emergency Room department setting, in addition to personal stresses, contributed to these errors. She stated she would never work in an Emergency Room setting again.

d. Ms. Brown is unable to practice nursing due to mental or physical illness which renders her unsafe to practice. Specifically, Ms. Brown acknowledged to her supervisors that she may suffer

from a mental disorder which causes her difficulty in concentrating and staying focused, and for which she has not been receiving treatment. She stated she was diagnosed as a child with a mental disorder but thought she "outgrew" it. She stated that it may, however, have been a contributing factor to her nursing practice issues.

e. Ms. Brown's employment was terminated on April 30, 2009.

3. Ms. Brown stated that she was employed at John Randolph Hospital, Hopewell, Virginia from June, 2009, through November 5, 2009. Her employment was terminated due to falsification of her application for employment in that she failed to disclose her termination from Regional Memorial Hospital.

4. Ms. Brown stated that she entered into a Participation Contract with the Health Practitioners' Monitoring Program ("HPMP") on November 19, 2009. She did not provide a copy of the signed contract.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 2(a)(i) through (viiii) constitute a violation of § 54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(2)(c) and (e) of the Regulations Governing the Practice of Nursing.

2. Finding of Fact No. 2(d) constitutes a violation of § 54.1-3007(6) of the Code.

CONSENT

Penny G. Brown, R.N., by affixing her signature hereon, agrees to the following:

1. She has been advised to seek advice of counsel prior to signing this document;

2. She acknowledges that without her consent, no legal action can be taken against her except pursuant to the Virginia Administrative Process Act, § 2.2-4000(A) *et seq*. of the Code;

3. She acknowledges that she has the following rights, among others: the right to a formal fact

finding hearing before the Board, the right to reasonable notice of said hearing, the right to representation by counsel, and the right to cross-examine witnesses against her;

4. She waives all such right to a formal hearing;

5. She admits to the Findings of Fact contained herein and waives her right to contest such Findings of Fact in any subsequent proceeding before the Board;

6. She consents to the entry of the following Order affecting her right to practice professional nursing in Virginia.

ORDER

WHEREFORE, on the basis of the foregoing, the Virginia Board of Nursing, effective upon entry of this Order, and in lieu of further proceedings, hereby ORDERS as follows:

1. License No. 0001-173424 of Penny G. Brown, R.N., is INDEFINITELY SUSPENDED.

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

3. At such time as Ms. Brown 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. Brown 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.

5. This suspension shall be STAYED upon proof of entry into 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. Brown 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 Penny G. Brown, R.N., 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. Brown is not in compliance with the terms and conditions specified by the HPMP;

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

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

6. This order shall be applicable to Ms. Brown's multistate licensure privilege, if any, to practice professional nursing in the Commonwealth of Virginia. For the duration of this Order, Ms. Brown shall not work outside 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 Ms. Brown wishes to work. Any request for out of state employment shall be directed, in writing, to the Executive Director of the Board.

7. Ms. Brown shall enroll in and successfully complete the following courses through the NCSBN Learning Extension: "Medication Errors: Detection and Prevention" and "Documentation: A Critical Aspect of Client Care." Ms. Brown shall provide the Board with verification that she has successfully completed the coursework within 45 days of the date this Consent Order is entered.

8. Ms. Brown shall maintain a course of conduct in her capacity as a professional nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Regulations Governing the Practice of 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 upon request.

FOR THE BOARD

Lynne Cooper
Lynne Cooper
President, Virginia Board of Nursing

ENTERED: January 26th, 2010

SEEN AND AGREED TO:

Penny G Brown RN
Penny G. Brown, R.N.

COMMONWEALTH OF VIRGINIA,
COUNTY/CITY OF New Kent, TO WIT: Notarized Peggy G. Brown, RN Sign. Only

Subscribed and sworn to before me, ~~28th~~ Penelope Wynn, a Notary Public, this 28th day of December, 2009.

My commission expires 10/31/10.

Registration Number 4158561.

PENELOPE L. WYNN
NOTARY PUBLIC
REG. #4158561
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES 10/31/10

Penelope L Wynn
NOTARY PUBLIC