VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: **ANDREW INTIAKO, L.P.N.**
LICENSE NO.: 0002-071713

NOTICE OF HEARING

Pursuant to §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11) of the Code of Virginia (1950), as amended ("Code"), Andrew Intiako, L.P.N., who holds License No. 0002-071713, which expires on May 31, 2013, is hereby given notice that a formal administrative hearing will be held in the presence of a panel of the Board of Nursing. The hearing will be held on December 6, 2011, at 1:00 p.m., at the offices of the Department of Health Professions, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233, at which time Mr. Intiako will be afforded the opportunity to be heard in person or by counsel.

At the hearing, Mr. Intiako has the following rights, among others: the right to representation by counsel; the right to have witnesses subpoenaed and to present witnesses on his behalf; the right to present documentary evidence; and the right to cross-examine adverse witnesses. If Mr. Intiako desires any witnesses to appear on his behalf, he must notify the Director of Administrative Proceedings, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in accordance with the Instructions for Requesting Subpoenas.

The purpose of the hearing is to inquire into evidence that Mr. Intiako may have violated certain laws and regulations governing practical nursing practice in Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board alleges that Andrew Intiako, L.P.N., may have violated § 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 in that:

1. During the course of Mr. Intiako's employment with The Virginian, Fairfax, Virginia:

a. On or about October 6, 2010 at 9:00 p.m., he left a cup, containing two dosage units of Percocet, in a drawer next to the narcotic box. The cup, which was labeled with Resident A's name and the time, was discovered at 7:00 a.m. the next morning. Mr. Intiako signed out the Percocet on the narcotic sheet, but not on the medication administration sheet.

b. On or about October 6, 2010, he was asked by a nurse where he had left insulin, which needed to be refrigerated, for a resident in room 52. Mr. Intiako stated that he left the insulin in the refrigerator. The insulin was found in room 47.

c. On or about July 28, 2010, he failed to administer one dosage unit of 30 mg of Lovanox (enoxaparin, Schedule VI) to Resident B, which was ordered by a physician.

2. During the course of Mr. Intiako's employment with The Gardens at Fair Oaks, Fairfax, Virginia:

a. On or about December 29, 2009, at 9:30 a.m., he was instructed to inform a physician by phone that the wound dressings of Resident C, who was on an anticoagulant, were saturated with blood. At or about 2:40 p.m., he informed a member of the nursing staff that the physician's office returned the call and ordered that Resident C be taken to urgent care if the bleeding continued. However, Mr. Intiako failed to document that he called the physician and the physician's subsequent order. Mr. Intiako also failed to pass this information to the next shift. At or about 5:00 p.m., another nurse found Resident C's wound dressing saturated with blood, and Resident C was eventually transported to urgent care.

b. On or about October 26, 2008, Mr. Intiako documented that he completed a dressing for Resident D. On or about October 27, 2008, when the dressing was due to be changed, the dressing was found dated October 25, 2008. By Mr. Intiako's own admission, he did not administer the dressing, but signed for it by mistake.

FOR THE BOARD

Jay P. Douglas R.N., M.S.M., C.S.A.C.
Executive Director for the
Board of Nursing

ENTERED: November 4TH, 2011