David E. Brown, D.C.
Director

COMMONWEALTH of VIRGINIA

Department of Health Professions
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May 15, 2014

Regina Ruth Hodges
14020 Campaign Court
Fredericksburg, VA 22407

CERTIFIED MAIL

DUPLICATE COPY
VIA FIRST CLASS MAIL
DATE 5/15/14

RE: License No.: 0002-054895

Dear Ms. Hodges:

Pursuant to Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), you are hereby given notice that your license to practice nursing in the Commonwealth of Virginia has been mandatorily suspended by the enclosed Order entered May 15, 2014. You are hereby advised that, pursuant to Section 54.1-2409.1 of the Code, any person who practices a profession or occupation after having their license or certificate to do so suspended shall be guilty of a felony. Please return your license to Jay P. Douglas, Executive Director of the Virginia Board of Nursing, at the above address, immediately upon receipt of this letter.

Section 54.1-2409 of the Code further provides that you may apply to the Board of Nursing ("Board") for reinstatement of your license, and shall be entitled to a hearing not later than the next regular meeting of the Board after the expiration of sixty days from the receipt of such reinstatement application. You have the following rights, among others: to be represented by legal counsel, to have witnesses subpoenaed on your behalf, to present documentary evidence and to cross-examine adverse witnesses. The reinstatement of your license shall require the affirmative vote of three-fourths of the members present of the Board of Nursing.

Should you wish to petition the Board of Nursing for reinstatement of your license, contact Jay P. Douglas, Executive Director, at the above address or (804) 367-4599.

Sincerely,

David E. Brown, D.C., Director
Department of Health Professions

Enclosures
Case # 156080

VIRGINIA:

BEFORE THE DEPARTMENT OF HEALTH PROFESSIONS

IN RE: REGINA RUTH HODGES, L.P.N.
License No.: 0002-054895

ORDER

In accordance with Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), I, David E. Brown, D.C., Director of the Virginia Department of Health Professions, received and acted upon evidence that the privilege of Regina Ruth Hodges, L.P.N., to practice nursing through the Nurse Licensure Compact in the State of Maryland was revoked by a Final Decision and Order of Revocation of Licensed Practical Nurse Privilege dated February 5, 2014. A certified copy of the Final Decision and Order of Revocation of Licensed Practical Nurse Privilege is attached to this Order and is marked as Commonwealth's Exhibit No. 1.

WHEREFORE, by the authority vested in the Director of the Department of Health Professions pursuant to Section 54.1-2409 of the Code, it is hereby ORDERED that the privilege of Regina Ruth Hodges, L.P.N., to renew her license to practice nursing in the Commonwealth of Virginia be, and hereby is, SUSPENDED.

Upon entry of this Order, the license of Regina Ruth Hodges, L.P.N., will be recorded as suspended and no longer current. Should Ms. Hodges seek reinstatement of her license pursuant to Section 54.1-2409 of the Code, she shall be responsible for any fees that may be required for the reinstatement and renewal of her license prior to issuance of her license to resume practice.

Pursuant to Sections 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 a public record and shall be made available for public inspection and copying upon request.

David E. Brown, D.C., Director
Department of Health Professions

ENTERED: 5/15/14

David E. Brown, D.C.
Director

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CERTIFICATION OF DUPLICATE RECORDS

I, David E. Brown, D.C., Director of the Department of Health Professions, hereby certify that the attached Final Decision and Order of Revocation of Licensed Practical Nurse Privilege dated February 5, 2014, regarding Regina Ruth Hodges, L.P.N., is a true copy of the records received from the Maryland Board of Nursing.

David E. Brown, D.C.

Date: 5/15/14

IN THE MATTER OF	*	**BEFORE THE**
REGINA HODGES	*	**MARYLAND BOARD**
MULTISTATE LICENSING PRIVILEGE TO PRACTICE LICENSED PRACTICAL NURSING	*	**OF NURSING**

* * * * * * * * * * * * *

FINAL DECISION AND ORDER OF REVOCATION OF LICENSED PRACTICAL NURSE PRIVILEGE

I. PROCEDURAL BACKGROUND

On or about April 19, 2012, the Maryland Board of Nursing (the "Board") received a complaint about the licensed practical nursing ("LPN") practice of Regina Hodges (the "Respondent"). The Board conducted an investigation, and based on the information provided to the Board during the investigation, by letter dated August 22, 2013, the Board charged the Respondent with violating the Nurse Practice Act, Md. Code Ann., Health Occ. ("HO") §§ 8-101, *et seq.* (the "Charges"), specifically HO § 8-316(a):

(5) Willfully and knowingly:

(i) Files a false report or record of an individual under the licensee's care;

(8) Does an act that is inconsistent with generally accepted professional standards in the practice of registered nursing; and

(25) Engages in conduct that violates the professional code of ethics, specifically:

COMAR 10.27.19.02B A nurse may not, when acting in the capacity or identity of a licensed nurse:

(1) Knowingly participate in or condone dishonesty, fraud, deceit or misrepresentation.

The Charges also notified the Respondent of her opportunity to request an evidentiary hearing before the Board. Additionally, the Respondent was placed on notice that if a request for an evidentiary hearing was not sent within the thirty days, she would waive her right to request a hearing, and the Board may take action against her multistate LPN privilege.

The Respondent failed to request an evidentiary hearing. On November 19, 2013, a quorum of the Board was present and, pursuant to Md. Code Ann., State Gov't § 10-210(4), a default proceeding was held. Denise McKoy, administrative prosecutor, presented the case on behalf of the State of Maryland.

II. FINDINGS OF FACT

The Board makes the following findings of fact based upon the entirety of the record:

1. On July 8, 1997, the Respondent was issued a license (0002054895) to practice as a licensed practical nurse in the State of Virginia.[1] Her Virginia license expired on June 30, 2012.

2. On or about April 19, 2012, the Board received a complaint from a skilled nursing facility located in Silver Spring, Maryland (the "LTC").

3. According to the complaint, on April 2, 2012, the Respondent "possibly created a falsified lab document" and sent a resident to the hospital based on a reportedly verbal and a faxed lab result. After conducting an investigation, the LTC terminated the Respondent's employment on April 20, 2012.

4. On April 2, 2012, the Respondent was assigned to work the 7:00 am to 3:00 pm shift. Her assignment included the care of Residents RS and GG.

5. The Director of Nursing Services ("DNS") reported that on April 2, 2012, between 10:00 am and 11:00 am, the Respondent informed her that she received a lab result showing Resident RS had a critical hemoglobin and hematocrit ("h/h") and that she received an order to send the resident to the emergency room.

[1] Under the Multi-state Licensure Compact (the "Compact"), HO § 8-7A-01, Virginia is a compact state and the Respondent is allowed to practice under the multi-state licensing privilege in any State that is a party to the Compact. The State of Maryland is a party to the Compact.

6. Later in the day, after the Respondent gave report to the evening shift nurse, it was discovered that another resident had the identical results as Resident RS. It was further discovered that Resident RS did not have a CBC drawn on April 2, 2012 but did have a urine analysis sent on that date.

7. The DNS instructed the Respondent to contact the emergency room and the doctor. The Respondent then showed the DNS the lab report for Resident RS with the CBC results.

8. The lab report presented by Respondent to the DNS was a copy of a printout from Citrano Medical Laboratories ("CML") for Resident RS, showing the results of a CBC with diff, collected on April 1, 2012 and received on April 2, 2012, with notations "called to doctor" and "send to ER."

9. The DNS contacted CML and reported what she thought was a lab error and an investigation was conducted by CML. CML was a new laboratory hired by LTC, effective April 1, 2012.

10. In an email to the DNS, dated April 13, 2013, the Respondent wrote:

> [I]n regards to lab results for [Resident] RS['s] CBC. CBC lab result noted with other lab results on desk in a pile. Called to [Doctor] with order to send to ER due to change in H/H and order carried out. Later during shift report, 3 – 11 nurse getting shift report had lab results for another resident with same CBC results, lab called, with no record of CBC being done for RS for that day.

11. RN reported that on April 2, 2012, she was receiving shift report from the Respondent and RN had picked up "some recently faxed lab results" and had them with her. Reportedly, the Respondent "suddenly stopped and said something to the effect of – let me see those lab results, they're the same as RS. I just sent her to the hospital because of those lab results."

CML Investigation

12. CML's Incident Report indicates that on April 3, 2012, the lab received a complaint from the DNS that Resident RS's report had the wrong results and that the resident was sent to the emergency room after the wrong results were transmitted to LTC.

13. The investigation by CML found no evidence of a report with CBC results for Resident RS but Resident RS did have a urine specimen submitted; the results of the urine test were transmitted in the afternoon and the CBC results for Resident GG were transmitted in the morning after the abnormal H/H had been called to "Regina" at 9:49 am; the report faxed by the DNS to CML had Resident RS's name but the results for Resident GG.

14. A comprehensive investigation by CML concluded the error did not occur during transmission.

Resident GG

15. On March 27, 2012, Resident GG was admitted to LTC with diagnoses of Traumatic fracture of hip, rodding on March 24, 2012, and post-op anemia requiring two units of blood.

16. Resident GG's doctor's orders included: "CBC next lab draw."

17. On March 28, 2012, at 5:00 pm, the following was documented in the Interdisciplinary Progress Notes ("Notes"): "CBC lab results received. Lab results read to Dr. Dave. H/H 8.1/23.3. New Order for repeat CBC in one week received."

18. Lab results from CML, with date/time April 2, 2012 at 2:41 pm noted on faxed copy, indicated that CBC w/diff was collected and received on April 2, 2012. The results show an H/H of 8.2/24.

Resident RS

19. Resident RS had diagnoses including Pneumonia and h/o Dementia. Her doctor's orders included: "3-29-12 order for a CBC in am and q month; 4-1-12 order for a urine analysis (UA) and urine culture and sensitivity (UC&S)."

20. Lab results received from Suburban Hospital indicated an H/H received on March 30, 2012 with a result of 10.4/31.

21. Lab results received from CML indicated the results of a urinalysis, which was collected on April 1, 2012 and received on April 2, 2012.

22. On April 2, 2012, the Respondent documented the following on Resident RS's Change Evaluation Form:

> Change Noted: Hgb/Hct 8.2/24
> Review of Lab/Diagnostic testing: last hgb/hct 3/22 11.2/33.5
> Additional information: {illegible} of order to send to [Hospital] ER 2° lab results
> Physician notified 1st call 1005 am; 2nd 11 am; 3rd 1150 am
> 911 called: 12:03 pm 911 arrived: 12:03 pm

23. On April 2, 2012 at 5:30 pm it was documented in the Notes: "Resident arrived back at [LTC] per ambulance, settled into room..."

Board Investigator's Interview of the DNS

24. During an interview, the DNS stated that she believed the lab report for Resident RS was altered. The DNS stated her belief that the Respondent wrote in the right upper hand and on the line that runs across Resident RS's report the words "called to doctor..." to hide an imperfection in the line due to the document being altered. The Board has reviewed the lab report for Resident RS and finds that is has been altered as described by the DNS.

25. The DNS also observed that the report indicated the date collected as April 1, 2012 and date received as April 2, 2012 and further observed that urinalysis results are usually

received the day after collection, not CBC results and that CBC results would usually have the same date for collection and date received.

26. The DNS stated her belief that the urinalysis lab results for Resident RS received on April 2, 2012 were used to alter the CBC results for Resident GG.

Respondent's Written Response to the Complaint

27. In a written response submitted on May 23, 2012 to the Board Investigator, the Respondent stated, in pertinent part:

> Regarding the lab incident on or about 4/2/2012, to the best of my recollection I thought I called in a copy of this lab that was noted on the desk for a resident early afternoon. I called this result to the doctor and followed order to send resident to hospital. I then went about my day. Upon giving report the 3 – 11 nurse brought a stack of the daily labs and asked if they had been noted by me earlier, they hadn't. Upon review I noted another low h/h result for resident. I compared the labs and noted the same results. I showed both copies to DON immediately and said that I might have made an error. I remember calling the hospital to tell them of a potential error I made. I called the lab and they had no evidence of performing a lab on resident sent to the hospital who was on her way back to facility...
>
> I should give the entire history for this time period. I have been having personal issues with resulting insomnia and anxiety; to cope I briefly took Klonopin previously prescribed. My memory of the last month of employ is not great, I needed to write things down at all times for recall otherwise forgot things. I had alarms to remind me to do things or I would forget, even things I never used to forget...
> I have years of ethical service and if I fouled up so badly and my behavior could be so abhorrent then I no longer deserve to be a nurse; ever again.

Discussion

28. After reviewing the urinalysis lab results for Resident RS, the CBC lab results for Resident GG, and the faxed lab report purporting to be CBC results for Resident RS, the Board finds that the urinalysis lab results for Resident RS were used to alter the CBC lab report for Resident GG. Specifically, it appears that the portion of the urinalysis lab report identifying Resident RS as the patient was superimposed onto the CBC lab report for Resident GG in order to create a "new" CBC lab report for Resident RS that included the identical CBC results as

Resident GG. Further, the Board finds that the circumstantial evidence supports the conclusion that the Respondent is responsible for creating the falsified CBC lab report for Resident RS in order to justify her earlier error in sending Resident RS to the emergency room. Accordingly, the Board finds that the Respondent violated HO § 8-316(a)(5)(i), (8), and (25).

29. The Board finds that the Respondent's misconduct falls within category F(2) of the Board's sanctioning guidelines. *See* COMAR 10.27.26.07F(2). The range of potential sanctions under category F(2) includes reprimand to revocation and/or a minimum fine of $1000.00 to a maximum fine of $5000.00 for license holders. *Id.* In light of the foregoing, the Board concludes that revocation of the Respondent's LPN privilege is the appropriate sanction in this case.

III. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent violated HO § 8-316(a):

(5) Willfully and knowingly:

(i) Files a false report or record of an individual under the licensee's care;

(8) Does an act that is inconsistent with generally accepted professional standards in the practice of registered nursing; and

(25) Engages in conduct that violates the professional code of ethics, specifically:

COMAR 10.27.19.02B A nurse may not, when acting in the capacity or identity of a licensed nurse:

(1) Knowingly participate in or condone dishonesty, fraud, deceit or misrepresentation.

IV. ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Respondent, Regina Hodges', multistate privilege to practice as a licensed practical nurse in the State of Maryland is hereby **REVOKED**; and be it further

ORDERED that this Order of Revocation of Licensed Practical Nurse Privilege is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't § 10-617(h) (2009).

February 5, 2014
Date

Patricia Ann Noble, MSN, RN
Executive Director
Maryland Board of Nursing

NOTICE OF APPEAL RIGHTS

Any person aggrieved by a final decision of the Board under Md. Code Ann., Health Occ. § 8-316(a) may take a direct judicial appeal within thirty (30) days of the date this Order is mailed as provided by Md. Code Ann., Health Occ. § 8-318(b), Md. Code Ann., State Gov't § 10-222, and Maryland Rule 7-203(a)(2) ("Time for Filing Action").