

**VIRGINIA:**

**BEFORE THE BOARD OF NURSING**

**IN RE: DEBRA G. PRINCE, L.P.N.**  
**License No.: 0002-040143**

**ORDER**

Pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), a Special Conference Committee ("Committee") of the Virginia Board of Nursing ("Board") met on April 15, 2013, in Henrico County, Virginia, to inquire into evidence that Debra G. Prince, L.P.N., may have violated certain laws and regulations governing practical nursing practice in Virginia. Ms. Prince was present and was represented by Anne Lahren, Esquire.

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

**FINDINGS OF FACT**

1. Debra G. Prince, L.P.N., was issued License No. 0002-040143 to practice as a practical nurse in the Commonwealth of Virginia on May 25, 1988. Said license expires on December 31, 2014. Ms. Prince's primary state of residence is Virginia.
2. By letter dated March 22, 2013, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Prince notifying her that an informal conference would be held on April 15, 2013. The Notice was sent by certified and first class mail to 3516 Plum Crescent, Virginia Beach, Virginia, 23453, the address of record on file with the Board of Nursing.
3. On August 18, 2012, during the course of her employment with ConMed Healthcare Management, while assigned to the Newport News, Virginia, City Jail, Ms. Prince failed to ensure that controlled medications were accurately counted at the beginning of her shift.

4. On July 18, 2011, during the course of her employment with ConMed Healthcare Management, while assigned to the Virginia Beach Correctional Facility, Ms. Prince responded to a call from a deputy requesting that she speak to a female inmate. The inmate had been incarcerated since the previous Friday, about 60 hours earlier, and had reported to the intake nurse that she was being tested for seizures or tremors. Ms. Prince stated that the deputy's communication was consistent with a non-emergency situation.

5. Upon arrival at the deputy station at approximately 5:00 a.m. with two other ConMed nurses, where the deputies were monitoring the inmate, Ms. Prince observed Inmate A to be hyperventilating. Ms. Prince observed her sitting down, bent over, with her hands over her face. The other two nurses began assisting the inmate and Ms. Prince stated at the informal conference that within a few moments, Inmate A began to calm down. The two other nurses checked Inmate A's pulse and monitored her respiration. No other vital signs were taken or documented, and neither Inmate A's pulse nor respiration were documented.

6. Ms. Prince stated at the informal conference that the supervising deputy decided to place Inmate A in an observation cell, a decision with which Ms. Prince agreed.

7. Ms. Prince stated at the informal conference that upon learning additional details about Inmate A, including the fact that the inmate had been treated by a neurologist, she reviewed Inmate A's intake form. She decided she would refer Inmate A to a consultation with the social worker, who was scheduled to arrive at the jail between 6:30 a.m. and 7:00 a.m.

8. Shortly after 6:30 a.m., Inmate A was discovered nonresponsive by deputies in the observation cell. Emergency medical staff responded to the observation cell, but they were unable to resuscitate Inmate A, who was pronounced dead. The cause of death was determined to be asphyxiation, caused by the blockage of Inmate A's airway by her plastic jail identification bracelet.

9. Following the incident with Inmate A, Ms. Prince was transferred to the Newport News City Jail, from which she resigned in August 2012. She is currently employed in a physician's office.

### CONCLUSIONS OF LAW

1. Finding of Fact No. 3 constitutes a violation of § 54.1-3007(5) of the Code.
2. Finding of Fact No. 5 constitutes a violation of § 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.

### ORDER

On the basis of the foregoing, the Committee hereby ORDERS as follows:

1. Debra G. Prince, L.P.N., is hereby REPRIMANDED.
2. Ms. Prince shall provide the Board with verification that she has completed the following NCSBN online course within 60 days of the date this Order is entered: *Sharpening Critical Thinking Skills for Competent Nursing Practice*.
3. Ms. Prince shall maintain a course of conduct in her capacity as a practical nurse commensurate with the requirements of § 54.1-3000 *et seq.* of the Code and the Board of Nursing Regulations.
4. Any violation of the terms and conditions of this Order or of any law or regulation affecting the practice of nursing in the Commonwealth of Virginia shall constitute grounds for the suspension or revocation of the license of Ms. Prince and an administrative proceeding shall be convened to determine whether such license shall be suspended or revoked.

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.

Pursuant to Section 54.1-2400(10) of the Code, Ms. Prince may, not later than 5:00 p.m., on June 12, 2013, notify Jay P. Douglas, Executive Director, Board of Nursing, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

FOR THE COMMITTEE:

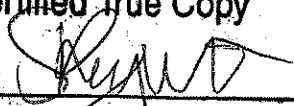


Jay P. Douglas, R.N., M.S.M., C.S.A.C.  
Executive Director, Virginia Board of Nursing

ENTERED: May 10<sup>th</sup>, 2013

This Order shall become final on June 12, 2013 unless a request for a formal administrative hearing is received as described above.

Certified True Copy

By   
Virginia Board of Nursing