IN THE MATTER OF PERMANENT REGISTERED NURSE LICENSE NUMBER 865315 ISSUED TO AMANDA JOY FORE, RESPONDENT	§ § § § § §	BEFORE THE TEXAS BOARD OF NURSING ELIGIBILITY AND DISCIPLINARY COMMITTEE

Executive Director of the Board

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

ORDER OF THE BOARD

TO: AMANDA JOY FORE
2700 FM 802, APT 1411
BROWNSVILLE, TX 78526

During open meeting held in Austin, Texas, on **September 8, 2015**, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 865315, previously issued to AMANDA JOY FORE, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

Entered this **8th day of September, 2015**.

TEXAS BOARD OF NURSING

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed July 8, 2015.

d17r(2014.12.05)

CERTIFICATE OF SERVICE

I hereby certify that on the 9 day of September, 2015, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
AMANDA JOY FORE
2700 FM 802, APT 1411
BROWNSVILLE, TX 78526

BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 865315	§	
Issued to AMANDA JOY FORE,	§	
Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, AMANDA JOY FORE, is a Registered Nurse holding License Number 865315, which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about May 2, 2014, Respondent submitted a Texas online endorsement application to the Texas Board of Nursing in which she provided false, deceptive, and/or misleading information, in that she answered "no" to the following question:

"Are you currently the target or subject of a grand jury or governmental agency investigation?"

Respondent failed to disclose that on or about October 16, 2013, she was sent a letter by the Maryland Board of Nursing requiring her to submit a written response to an investigation regarding allegations of diversion of medications. Respondent's conduct was likely to deceive the Board and could have affected the decision to issue a license.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(2) & (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(6)(I).

CHARGE II.

On or about March 31, 2015, Respondent's Maryland registered nurse license and certified nursing assistant certificate were Summarily Suspended by the Maryland Board of Nursing, Baltimore, Maryland. A copy of the Maryland Board of Nursing's Order for Summary Suspension dated March 31, 2015, is attached and incorporated, by reference, as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that to the extent applicable, based on the Formal Charges, the Board will rely on Adopted Disciplinary Sanction Policies for Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder, for Lying and Falsification, and for Fraud, Theft and Deception, which can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Maryland Board of Nursing's Order for Summary Suspension dated March 31, 2015.

Filed this 8th day of July, 2015.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Natalie E. Adelaja, Assistant General Counsel
State Bar No. 24064715
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
John F. Legris, Assistant General Counsel
State Bar No. 00785533
John Vanderford, Assistant General Counsel
State Bar No. 24086670

333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-8657
F: (512) 305-8101 or (512)305-7401

Attachments: Maryland Board of Nursing's Order for Summary Suspension dated March 31, 2015.

D(2015.02.24)

IN THE MATTER OF	*	**BEFORE THE**
	*	
AMANDA FORE	*	**MARYLAND BOARD**
AKA AMANDA GIBBS	*	
	*	**OF NURSING**
LICENSE NO.: R194287	*	
CERTIFICATE NO.: A00099721	*	

* *

ORDER FOR SUMMARY SUSPENSION OF REGISTERED NURSING LICENSE AND NURSING ASSISTANT CERTIFICATE
AND
NOTICE OF DISCIPLINARY CHARGES
UNDER THE MARYLANDNURSE PRACTICE ACT

BACKGROUND

On or about September 26, 2013, the Maryland Board of Nursing ("the Board") received a complaint from a hospital in Maryland hospital regarding the practice of Amanda Fore, aka Amanda Gibbs, (the "Respondent"), RN, License Number R194287; and, CNA, Certificate Number A0009972. The complaint alleges that from April 2013 through May 2013, while assigned to work at the hospital as a registered nurse, the Respondent diverted controlled substances, specifically Dilaudid[1], from the Pyxis.[2]

Based upon further investigation by the Board, the Board has reason, as set forth below, to find that the public health, safety or welfare imperatively requires emergency action under Md. Code Ann., State Gov't. § 10-226 (c) (2) (2014 Repl. Vol.).

---

[1] Dilaudid is the trade name for hyrdromophone. Dilaudid is a morphine type narcotic analgesic and Schedule II Controlled Substance. Dilaudid is 7-10 times more analgesic than morphine, with a shorter duration action..

[2] Pyxis is an automated drug-dispensing device that contains narcotics and other medications. Each time it is accessed, it records information including name of medication, dose, time of withdrawal, return of medication (if it is not used), patient name and identification of nurse accessing the medication. Each nurse has his/her own code or password to gain access to the medications.

Fore, Amanda
aka Gibbs, Amanda
R194287
A00099721
SS.Chges.

ALLEGATIONS OF FACT[3] AND REASONS IN SUPPORT OF SUMMARY SUSPENSION AND DISCIPLINARY CHARGES UNDER THE MARYLAND PRACTICE ACT

The Board has received reliable information that the following facts are true:

1. On or about February 10, 2011, the Board issued the Respondent a license to practice as a registered nurse ("RN") in the State of Maryland, license number R194287. According to the Board's MyLicense (MYLO) database, the status of the Respondent's Maryland RN license is "Invalid." The Respondent's Maryland RN license expires on July 28, 2016. The Compact[4] status of the Respondent's Maryland RN license is "Single State."
2. On or about July 7, 2009, the Board issued to the Respondent a certificate to practice as a certified nursing assistant ("CNA") in the State of Maryland, Certificate Number A00099721. The Respondent's CNA certificate is non-renewed having expired on July 28, 2012.
3. On or about September 26, 2013, the Board received a complaint from a hospital ("the Hospital")[5] in Maryland regarding the Respondent's practice as a registered nurse.

[3] The allegations set forth in this document are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.
[4] The Nurse Licensure Compact (NLC) is an agreement between Boards of Nursing of party states that allows nurses to have one Mutli-State nursing license with the ability to practice nursing in both their home state and other party states. In accordance with the Multistate Licensure Compact, Md. Health Occ. Code Ann. §8-7A-01.3(f) and §8-7A-01.3(j) respectively, "Home state" means the party state that is the nurse's primary state of residence ;and, "Party state" means any state that has adopted this Compact.
[5] To ensure confidentiality, the names of the hospital, nurses, directors, managers, pharmacists, technicians, Board Investigator, and other staff members are not set forth in this Order for Summary Suspension and Notice of Charges. The names are available to the Respondent upon request to the Administrative Prosecutor.

4. The Respondent began employment at the Hospital on May 15, 2009. In April and May 2013, the Respondent was working on the Hospital's Oncology Unit ("the Unit").

5. On April 30, 2013, a registered nurse ("Nurse A") and the Nurse Manager conducted a narcotics count of the hydrocodone (Dilaudid) located in Drawer 1, Pocket F[6] of the Unit's Pyxis. Pocket F was supposed to contain twenty-four (24) vials of 2mg injectable Dilaudid. There were only twenty (20) vials. The four (4) missing vials were listed as miscounted and the Pyxis was considered reconciled.

6. Drawer 1 (of the Unit's Pyxis) is a carousel style drawer that has pie-shaped pockets. At that time, Pocket F contained Dilaudid (hydromorphone). On either side of Pocket F was Pocket E, which contained Albuterol; and, Pocket G which contained oxycodone.

7. On May 13, 2013 at 10:00 p.m., two other nurses ("Nurse B and Nurse C") conducted an inventory narcotics count for the Dilaudid in Pocket F in the Unit's Pyxis. Pocket F was supposed to contain twenty (20) vials of 2 mg injectable Dilaudid. At the time of the count, the drawer only contained seven (7) vials.

8. On May 14, 2013 at 8:10 a.m., ten hours after Nurse B and Nurse C counted only seven vials in Pocket F, a pharmacy technician accessed Pocket F in the Unit's Pyxis to restock the Dilaudid. Before restocking, the pharmacy technician found only one (1) vial of Dilaudid in Pocket F.

[6] According to the Investigations Unit Report, a nurse reported to the Nurse Manager that Drawer 1 in the Unit Pyxis had recently malfunctioned. The Nurse Manager was told that when the nurse entered a request to access Drawer 1, Pocket F (containing the Dilaudid), Drawer 1 opened to Pocket D which contained Dextrose.

9. The Hospital's Director of Investigations conducted an investigation and audit of the Pyxis activity by the nurses who worked between April 27, 2013 and May 14, 2013. The Director of Investigation found the following:

a. Between April 27, 2013 and April 30, 2013 four (4) vials of Dilaudid were taken from the Pyxis;

b. Between May 7, 2013 and May 13, 2013, thirteen (13) vials of Dilaudid were taken from the Pyxis; and,

c. Between 10:00 p.m. on May 13, 2013 and 8:10 a.m. on May 14, 2013, six vials of Dilaudid were taken from the Pyxis.

10. The Director of Investigations then compared the periods that the Dilaudid vials were taken with the Pyxis records of nurses who accessed the Pyxis and found that the Respondent was the only nurse that accessed the Pyxis during all three time periods.

11. According to the Pyxis records, at 10:35 p.m. on May 13, 2013, the Respondent accessed Drawer 1, Pocket G of the Pyxis to remove oxycodone for a patient. The Respondent was the only person to access Drawer 1 in the ten hour period between 10:00 p.m. on May 13, 2013 and 8:10 a.m. on May 14, 2013.

12. According to the Investigations Unit Report, it was discovered on or about May 16, 2013 that Drawer 1 in the Pyxis had been malfunctioning. A nurse ("Nurse E") reported to the Nurse Manager that when she (Nurse E) entered a request to access Drawer 1, Pocket F (containing the Dilaudid), Drawer 1 opened to Pocket E, stopping one pocket short of the correct medication. The Director of Investigations also found that Drawer 1 would sometimes open to a middle area between two pockets allowing access to both pockets of medications.

13. The Director of Investigations interviewed the Respondent regarding her access of the Pyxis on May 13, 2013 after the 10:00 p.m. inventory. The Respondent denied taking the six Dilaudid vials. At the interview, the Director of Investigations told the Respondent she was being referred to take a "for-cause" drug test.

14. The Respondent told the Director of Investigations that the test would probably come back positive. The Director of Investigations told the Respondent that the Hospital was aware[7] of her prescription for Nucynta[8] and that she should not be concerned about testing positive for Nucynta.

15. The Respondent submitted to the for-cause drug test on June 25, 2013. Prior to submitting to the drug test, the Respondent said the only medications she had taken were Nucynta and Ambien. The Respondent admitted to having full bottles of Celebrex, Prilosec, Neurontin, and Opana[9] at her home. She said the medications were prescribed to her, but the Respondent denied taking any of the medications.

16. On or about July 2, 2013[10], the Hospital was notified that the Respondent's drug test was positive for oxymorphone (Opana) and diphenhydramine (Benadryl).

17. On August 12, 2013, the Nurse Manager, Assistant Director of Nursing, Human Resources Liaison, and Nurse Clinician met with the Respondent to discuss the

[7] The Respondent had been in an automobile accident in 2009 and the Hospital was aware of her pain management treatment.
[8] Nucynta is the trade name for tapentadol HCL, an opioid analgesic. Nucynta is a Schedule II controlled substance.
[9] Opana is the trade name for oxymorphone hydrochloride. Opana is an opioid analgesic and Schedule II controlled substance.
[10] While the drug test results were pending, the Hospital referred the Respondent to Occupational Health Services for a fitness for duty evaluation on or about June 26, 2013.

Hospital's internal investigation of the theft of twenty-three vials of Dilaudid from the narcotic Pyxis on the Unit. Initially, the Respondent denied stealing the Dilaudid vials. Later, during the meeting, the Respondent asked to speak to the Nurse Manager alone. The Respondent told the Nurse Manager that she had taken the Dilaudid on three separate occasions when she accessed the Pyxis to withdrawal oxycodone pills for patients. The Respondent said the oxycodone drawer in the Pyxis was next to the drawer that contained the Dilaudid. The Respondent told the Nurse Manager that when she accessed the oxycodone, the drawer to the Diluadid was partially open and she would remove several vials each time.

18. The Respondent told the Nurse Manager that she had taken the Diluadid for her husband, and not for her own personal use.

19. After the meeting, on August 12, 2013, the Respondent resigned from her employment at the Hospital in lieu of being terminated.

20. On or about October 16, 2013, the Board sent the Respondent a letter informing her that the Board had received a complaint from the Hospital regarding allegations that she had diverted medications during April and May 2013. The letter required the Respondent to contact the Board's Investigator and send a written response to the Board within ten days of receipt of the letter. The Respondent failed to send a written response to the Board.

21. On or about May 5, 2014, the Board sent the Respondent a letter again informing her that the Board had received a complaint from the Hospital regarding

allegations that she had diverted medications during April and May 2013. The letter required the Respondent to contact the Board's Investigator and send a written response to the Board within ten days of receipt of the letter. The Respondent failed to send a written response to the Board.

22. On May 6, 2014, the Board sent the Respondent a summons ordering the Respondent to appear at the Board's offices on June 16, 2014 at 11:00 a.m. for an interview with the Board's Investigator.

23. On May 12, 2014, the Board Investigator telephoned the Respondent. The Respondent acknowledged receiving the October 16, 2013 letter, May 5, 2014 letter, and May 6, 2014 summons to appear at the Board. The Respondent told the Board's Investigator said she would provide the Board a written statement and come to the Board for the interview. When asked whether she took the Dilaudid from the Hospital, the Respondent did not answer. The Respondent told the Board's Investigator that she was going through a rough time with her husband and she was separated. The Respondent denied plans to move to Texas.

24. The Respondent failed to appear at the Board's offices on June 16, 2014 for an interview.

25. On August 18, 2014, the Board issued a second summons to the Respondent to appear at the Board's offices on September 16, 2014 for an interview. The Respondent failed to appear at the Board's offices on September 16, 2014.

26. According to NURSYS[11], on or about September 24, 2014, the Texas Board of Nursing issued the Respondent a license to practice registered nursing in the State of Texas, License Number 86513. The Respondent's Texas RN license is active and due to expire on July 31, 2016. The Compact status of the Respondent's Texas RN license is "Multi-State."

27. The Respondent's positive drug screen results and admission to the diversion of controlled narcotics, specifically Dilaudid, are actions consistent with an individual who has a chemical dependency or problem with addiction. At this time, the Respondent's nursing practice is unmonitored and there is no way to ensure that the Respondent is sober, making her practice as a registered nurse a danger to all patients under her care. Based on the information in paragraphs 1 through 27, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case.

28. Based on the allegations of fact under Background and in paragraphs 1 through 27, the Board voted to charge Respondent with violations of the Nurse Practice Act (the "Act"), Md. Code Ann., Health Occupations Article, §§ 8-101 *et. seq.* (2014 Repl. Vol.) as listed below. The pertinent provisions of Health Occupations Article and the violations under which the above allegations of fact in paragraphs 1 through 27 are brought and for which the Board has charged Respondent, are as follows:

[11] NURSYS is a national database for verification of nurse licensure, discipline and practice privileges for participating jurisdictions, including all states in the Nurse Licensure Compact in conjunction with the National Council of State Boards of Nursing (NCSBN).

§ 8-316 (a) *Penalties.* –Subject to the hearing provisions of § 8-317 of this subtitle, the Board may . . . reprimand any licensee, place any licensee on probation, or suspend or revoke the license of a licensee if the . . .licensee:

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

(20) Fails to cooperate with a lawful investigation conducted by the Board;

(25) Engages in conduct that violates the professional code of ethics; to wit,

COMAR 10.27.19.02.C. A nurse may not engage in behavior that dishonors the profession whether or not acting in the capacity or identity of a licensed nurse, including, but not limited to:

(3) Deceiving, defrauding, or stealing from a coworker, employer, client, or client's family member;

(8) Using, possessing, supplying, administering, or attempting to use, possess, supply, or administer prescription drugs or controlled dangerous substances without valid medical indication;

And

§ 8-6A-10 (a), *Penalties* - Subject to the hearing provisions of § 8-317 of this title, the Board may . . . reprimand any certificate holder, place any certificate holder on probation, or suspend or revoke the certificate of a certificate holder, if the applicant or certificate holder:

(20) Has violated any provision of this title or has aided or knowingly permitted any person to violate any provision of this title; *to wit, § 8-316(a) (8), (20), and (25)*

(26) After failing to renew a certificate, commits any act that would be grounds for disciplinary action under this section; *to wit, § 8-6A-10 (a)(20)*

The applicable section of SG § 10-226 (c) (2) provides that:

> (2) A unit may order summarily the suspension of a license if the unit:
>
> (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
> (ii) promptly gives the licensee:
>
> 1. Written notice of the suspension, the finding and the reasons that support the finding; and
> 2. An opportunity to be heard.

CONCLUSIONS OF LAW

Based on the foregoing investigative information, the Board finds that the public health, safety or welfare imperatively requires emergency action in this case, pursuant to Md. Code Ann., State Gov't. § 10-226 (c) (2) (2009 Repl. Vol. & 2011 Supp.).

ORDER

It is hereby:

ORDERED that, pursuant to the authority vested in the Board by Md. Code Ann., Health Occ., § 8-316 (a) and § 8-6A-10 (a) (2014 Repl. Vol.); and Md. Code Ann., State Gov't., § 10-226 (c)(2) (2014 Repl. Vol.), the license (R194287) and certificate (A00099721) of Amanda Fore, aka Amanda Gibbs, an individual licensed to practice as a Registered Nurse and certified to practice as a Certified Nursing Assistant in the State of Maryland, are hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that, there will be a Show Cause Hearing on **Tuesday, April 28, 2015** at **10:00 a.m. before** the Board at the Board of Nursing, 4140 Patterson Avenue, Baltimore,

Maryland 21215, for Respondent to have the opportunity to show cause as to why the Respondent's license and certificate should not be suspended; and be it further

ORDERED that, if the suspension of the Respondent's license and/or certificate is continued following a Show Cause Hearing, the Respondent has the right to a full evidentiary hearing before the Board and a hearing will be scheduled before the Board if the Respondent submits a written request for an evidentiary hearing to the Board no later than thirty (30) days from the date of the Board's written decision issued after the Show Cause Hearing; and be it further

ORDERED that, if Respondent requests an evidentiary hearing, the proceedings before the Board will be conducted in accordance with the Maryland Administrative Procedure Act (APA), Md. Code Ann., State Gov't §10-201 *et. seq.*, the Maryland Nurse Practice Act, Md. Code Ann., Health Occ. §8-317 and the Board's regulations at COMAR 10.27.02 *et.seq.* The APA gives the Respondent the right to be represented by counsel authorized to practice law in Maryland, to request subpoenas for evidence and witnesses, to call witnesses, to present evidence, to cross-examine every witness called by the State, to obtain a copy of the hearing procedures upon request, and to present summation and argument. Unless otherwise prohibited by law, the Respondent may agree to the evidence and waive the Respondent's right to appear at the hearing; and be it further

ORDERED that, if the Respondent does not submit a written request to the Board for an evidentiary hearing within 30 days from the date of the Board's written decision issued after the Show Cause Hearing, the Respondent shall have waived all rights now and in the future to any

hearing on the summary suspension, disciplinary charges, and factual allegation in this Order for Summary Suspension and Notice of Disciplinary Charges; and be it further

ORDERED that, if no hearing is requested by the Respondent, pursuant to the authority of § 8-316(a) and § 8-6A-10(a) of the Maryland Nurse Practice Act, and §§ 10-210(4) and 10-221 of the APA, the Board may, in its discretion, issue a public Final Decision and Order by default, in which: (1) the summary suspension of the Respondent's license and certificate is affirmed; (2) the allegations of fact in this document become findings of fact; (3) the alleged violations under § 8-316(a) and § 8-6A-10(a) of the Maryland Nurse Practice Act cited in this document become conclusions of law; and (4) a disciplinary sanction pursuant to Md. Code Ann., Health Occ. § 1-606 (2014 Repl. Vol.) and COMAR 10.27.26 is ordered against the Respondent's license, which may include reprimand, probation, suspension, revocation and/or a monetary fine; and is it further

ORDERED that this document entitled, "Order for Summary Suspension of Registered Nursing License and Certified Nursing Assistant Certificate and Notice of Disciplinary Charges Under the Maryland Nurse Practice Act," is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov., § 4-101, *et seq.* and § 4-333 (2014).

MAR 31 2015
Date

Alice Williams
Acting Deputy
Mary Kay Goetter, PhD, RN, NEA-BC
Executive Director
Maryland Board of Nursing