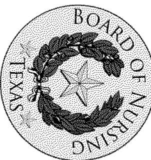


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 948856	§	**BOARD OF NURSING**
Issued to LARRY STEPHEN LAURENT,	§	
Respondent	§	**ELIGIBILITY AND**
		DISCIPLINARY COMMITTEE

ORDER OF THE BOARD

TO: Larry Laurent
6007 Grissom Rd
Unit 2305
San Antonio, TX 78238

During open meeting held in Austin, Texas, on November 9, 2021, 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 948856, previously issued to LARRY STEPHEN LAURENT 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 9th day of November, 2021

TEXAS BOARD OF NURSING

BY:

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

Attachment: Formal Charges filed April 21, 2021

d17r(2021.09.20)

Re: Permanent Registered Nurse License Number 948856
Issued to LARRY STEPHEN LAURENT
DEFAULT ORDER - REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 9th day of November, 2021, 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,
Copy Via USPS First Class Mail

Larry Laurent
6007 Grissom Rd
Unit 2305
San Antonio, TX 78238

BY:

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

In the Matter of Permanent Registered Nurse License Number 948856 Issued to LARRY STEPHEN LAURENT, Respondent	§ § § § §	BEFORE THE TEXAS BOARD OF NURSING

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, LARRY STEPHEN LAURENT, is a Registered Nurse holding license number 948856 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 September 16, 2020, Respondent's California Registered Nurse License was issued a Default Decision and Order, wherein Respondent's license to practice professional nursing in the State of California was revoked. A copy of the Default Decision and Order from the Board of Registered Nursing, Department of Consumer Affairs, State of California, dated September 16, 2020, is attached and incorporated by reference a part of this pleading.

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

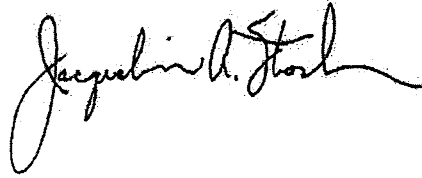
NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license(s) and/or privilege(s) to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33.

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, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, located at 22 TEX. ADMIN. CODE §213.33(b), which can be found under the "Discipline & Complaints; Board Policies & Guidelines" section of the Board's website, www.bon.texas.gov.

Filed this 21st day of April, 2021.

TEXAS BOARD OF NURSING



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Austin, Texas 78701
P: (512) 305-8657
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I hereby certify the foregoing to be a true copy of the documents on file in our office.

BOARD OF REGISTERED NURSING

Loretta Melby, RN, MSN
Executive Officer

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LARRY STEPHEN LAURENT** 1492 Kingswood Dr. Roseville, CA 95678 **Registered Nurse License No. 95053436** Respondent.	Case No. 4002018006234 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about July 21, 2020, Complainant Loretta Melby, R.N., M.S.N., in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, filed Accusation No. 4002018006234 against Larry Stephen Laurent (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about February 6, 2015, the Board issued Registered Nurse License No. 95053436 to Respondent. The Registered Nurse License will expire on September 20, 2022, unless renewed.

3. On or about July 22, 2020, Respondent was served by Certified and First Class Mail copies of the Accusation No. 4002018006234, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6,

1 and 11507.7) at Respondent's address of record which, pursuant to California Code of
2 Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board.
3 Respondent's address of record was and is: 1492 Kingswood Dr., Roseville, CA 95678.

4 4. Service of the Accusation was effective as a matter of law under the provisions of
5 Government Code section 11505(c) and/or Business and Professions Code section 124.

6 5. Government Code section 11506(c) states, in pertinent part:

7 (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense . . . and the notice shall be deemed a specific denial of all
8 parts of the accusation . . . not expressly admitted. Failure to file a notice of defense . . . shall constitute a waiver of respondent's right to a hearing, but the agency in its
9 discretion may nevertheless grant a hearing.

10 6. The Board takes official notice of its records and the fact that Respondent failed to
11 file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore
12 waived his right to a hearing on the merits of Accusation No. 4002018006234.

13 7. California Government Code section 11520(a) states, in pertinent part:

14 (a) If the respondent either fails to file a notice of defense . . . or to appear at the hearing, the agency may take action based upon the respondent's express
15 admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent . . . .
16

17 8. Pursuant to its authority under Government Code section 11520, the Board finds
18 Respondent is in default. The Board will take action without further hearing and, based on the
19 relevant evidence contained in the Default Decision Investigatory Evidence Packet in this matter,
20 as well as taking official notice of all the investigatory reports, exhibits and statements contained
21 therein on file at the Board's offices regarding the allegations contained in Accusation No.
22 4002018006234, finds that the charges and allegations in Accusation No. 4002018006234, are
23 separately and severally, found to be true and correct by clear and convincing evidence.

24 **DETERMINATION OF ISSUES**

25 1. Based on the foregoing findings of fact, Respondent Larry Stephen Laurent has
26 subjected his Registered Nurse License No. 95053436 to discipline.

27 2. The agency has jurisdiction to adjudicate this case by default.
28

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case:

a. Violation of Business and Professions Code section 2761(a)(1), in that Respondent was grossly negligent within the meaning of California Code of Regulations, title 16, section 1442, when he departed from the standards of practice related to the administration and documentation of fentanyl, and to his access of patient records without a clinical need.

b. Violation of Business and Professions Code section 2761(a)(1), in that Respondent demonstrated incompetence with respect to his administration and documentation of fentanyl, and to his access of patient records without a clinical need.

c. Violation of Business and Professions Code section 2761(a) on the grounds of unprofessional conduct.

d. Violation of Business and Professions Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762 (a), in that on or about January 24, 2018, Respondent obtained the controlled substance fentanyl from his place of employment by fraud, deceit, misrepresentation, or subterfuge in violation of Health and Safety Code section 11173(a)

ORDER

IT IS SO ORDERED that Registered Nurse License No. 95053436, issued to Respondent Larry Stephen Laurent, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on October 16. 2020.

It is so ORDERED September 16, 2020

Shannon Johnson

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachment: Exhibit A: Accusation

Exhibit A

Accusation

(LARRY STEPHEN LAURENT)

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KENT D. HARRIS
Supervising Deputy Attorney General
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Attorneys for Complainant

**BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: **LARRY STEPHEN LAURENT** 1492 Kingswood Dr. Roseville, CA 95678 **Registered Nurse License No. 95053436** Respondent.	Case No. 4002018006234 **ACCUSATION**

PARTIES

1. Loretta Melby, R.N., M.S.N., (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about February 6, 2015, the Board issued Registered Nurse License Number 95053436 to Larry Stephen Laurent (Respondent). The Registered Nurse License will expire on September 30, 2022, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . .

7. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> . . .

8. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

///

9. Health and Safety Code section 11173, subdivision (a), states that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

11. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

12. California Code of Regulations, title 16, section 1443.5, states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
>
> (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
>
> (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
>
> (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
>
> (6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the

interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

13. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUG INFORMATION

14. *Fentanyl* is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8). It is used to treat severe pain.

15. *Propofol* is a short-acting, lipophilic intravenous general anesthetic. It is used as a sedative.

16. *Morphine* is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L). It used to treat moderate to severe chronic pain.

17. *Midazolam* is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(21). Midazolam Hydrochloride is also known as Versed and is in the benzodiazepine family. Midazolam is used for reducing anxiety or producing drowsiness or anesthesia before certain medical procedures or surgery.

FACTUAL ALLEGATIONS

18. At all times mentioned herein, Respondent was employed as a Clinical Nurse II with University of California Davis Medical Center (UCDMC) located in Sacramento, California. Respondent was assigned to work in the intensive care units (ICUs), caring for critically ill patients. Respondent worked the night shift from 19:00 to 07:00.

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Patient M.P.

19. During Respondent's shift from 19:00 on January 22, 2018, to 07:00 on January 23, registered nurse C.P. was assigned to care for Patient M.P. and Respondent was assigned to provide break coverage for C.P. from 03:00 to 04:00[1]. Prior to learning of this assignment and hours prior to assuming care of the patient, Respondent began viewing M.P.'s medication administration record (MAR) at 19:17, and viewed the patient's fentanyl order again at 00:13. During this shift, and prior to assuming coverage, Respondent asked C.P. about and expressed interest in Patient M.P.

20. Upon C.P.'s return from her 03:00 to 04:00 meal break, Respondent notified C.P. that he had contacted the resident to recommend an order of higher concentration fentanyl solution because M.P.'s drip was going at a high rate. C.P. acknowledged that the rate was high, but noted that it was odd for Respondent to do this because administration of the higher concentration fentanyl was extremely rare.[2]

21. During Respondent's shift from 19:00 on January 23, 2018, to 07:00 on January 24, 2018, he was assigned to one patient and was again designated to provide meal break coverage for C.P., who was assigned to patient M.P. During this shift, Respondent began accessing the M.P.'s MAR at 18:55, with significant access to the patient's record through 20:22. Beginning at 20:22, Respondent viewed the patient's EMR approximately every 30 minutes until assuming care of the patient at approximately 01:00 on January 24, 2018. Nearly all of this access was limited to the patient's MAR and order for fentanyl solution. Although C.P. was scheduled to take her lunch break from 03:00 to 04:00, she and Respondent switched schedules and C.P. took her meal break from 01:00 to 02:00. During this period, Respondent was responsible for monitoring patient M.P., as well as his own patient.

22. Prior to taking her break, C.P. provided a hand-off report about M.P. to Respondent. This included a review of M.P.'s propofol and fentanyl intravenous infusions (drip), and a

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[1] Break coverage assignments at UCDMC are typically set by the charge nurse between 21:00 and 22:00.

[2] Between December 1, 2017 and January 31, 2018, high concentration fentanyl solution was administered to five patients in the Surgical Intensive Care Unit (SICU) and Medical Intensive Care Unit (MICU) combined.

maintenance line with an antibiotic attached via a piggyback line. C.P. explained to Respondent that nothing needed to be done for the patient while she was on break and that he only needed to listen for alarms, and possibly increase the patient's propofol dose if the patient seemed anxious. Respondent mentioned that the current fentanyl drip would need to be changed soon, but C.P. objected and informed Respondent that the current bottle would last another two hours. When C.P. left for her meal break, M.P. was receiving a fentanyl drip at a rate of 100 mcg per hour (12.5 mL per hours). The fentanyl drip was administered at this rate beginning at 18:00, and if unchanged, the fentanyl would have run out at approximately 04:00. Nonetheless, Respondent conducted the following Pyxis transactions for M.P. during C.P's absence, ultimately removing a bag of fentanyl for MP at 1:32.

Transaction Time	Patient	Med Description	Device	Transaction Type	Quantity
1:16:10	MP	RXPATIENT SPECIFIC NARCOTIC	T2SI-LEFT	Override Cancelled[3]	0 EACH
1:32:16	MP	RX PATIENT SPECIFIC NARCOTIC (FENTANYL 1,000 MCG IN 100 mL Infusion)	T2SI-LEFT	Override	1 EACH

23. When C.P. returned from her break, she reported that Respondent had removed a fentanyl bag from Pyxis for Patient M.P. and set up the next fentanyl infusion. Although the original fentanyl was still being administered to M.P., the bag Respondent had removed from Pyxis was spiked[4] and near the patient's bed. C.P. also noted several irregularities inconsistent with how she left the patient's room, including: a half-filled 10 cc saline flush on the patient's bed; a flush cap and two grey needle caps on the floor; a 50 mL syringe in the sharps container; green alcohol caps missing from the ports on the patient's active fentanyl drip; the patient's

[3] Patient-specific medications are stored in a designated Pyxis drawer, referred to as the "RXPATIENT SPECIFIC" drawer. Access to this drawer is done utilizing the override function and medications in the drawer are identified as "RXPATIENT SPECIFIC NARCOTIC) 250 mL (1 each)." A cancelled override transaction allows the user to access the content of the corresponding Pyxis drawer, but indicates no medications were removed or returned. Cancelled transactions use the unspecified "RXPATIENT SPECIFIC NARCOTIC" medication description, whereas transactions where the medication removed or wasted is known will identify the medication in question.

[4] To insert a needle, in a sterile manner, into a bag containing a fluid being infused into a patient.

antibiotic was clamped closed and disconnected from the saline line; and the patient's propofol administration rate had been increased from 5 mcg per hour (2.3 mL per hour) to 10 mcg per hour (4.5 mL per hour).

24. C.P. questioned Respondent about the several irregularities identified upon her return from break, but Respondent was unable to provide an explanation. Respondent returned to the room several times to attempt to provide an explanation for his actions. C.P. promptly relayed her concerns to P.G., the charge nurse on duty, and noted that the increase in propofol rate caused the patient to be "pretty out of it." The bag of fentanyl set up by Respondent was immediately sequestered and was not administered to the patient. A sample from the sequestered bag was sent to an external laboratory, DynaLabs, for potency and purity testing. The test results showed that the fentanyl in the bag was diluted to approximately 32% of the expected concentration[5]. After speaking with C.P., P.G. was unable to locate Respondent in the unit for approximately 10-15 minutes.

25. As a result of the January 24, 2018 incident involving patient M.P., and because Respondent's practices for narcotic administration had previously been investigated[6], UCDMC initiated an investigation regarding Respondent's nursing practice. The investigation reviewed three specific items related to Respondent's nursing practice: (1) whether Respondent was responsible for diverting fentanyl from UCDMC on January 24, 2018; (2) a review of Respondent's fentanyl activity during the period between December 2017 and January 2018; and (3) a review of Respondent's access to the private health information of patients in the electronic medical record (EMR).

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[5] A 78 mL sample was sent to DynaLabs and subsequently divided and tested as three unique samples. Each sample resulted as being out-of-specification (OOS). An OOS determination is reached when test results fall outside of predetermined specification criteria. DynaLabs determined that the specimens tested at 32.8%, 32.9%, and 31.6% of target, compared to the specification of 90.0-110.0%.

[6] In August 2017, UCDMC conducted an audit of Respondent's practices and procedures regarding administration of narcotics to patients and found that Respondent administered higher narcotic dosages than nurses on previous or subsequent shifts. The audit was conducted following an interview with Respondent regarding missing narcotics tablets.

UCDMC Investigation of the January 24, 2018 Incident

26. On February 13, 2018, Respondent was interviewed by the UCDMC chief compliance officer regarding his actions with respect to the January 24, 2018 incident involving Patient M.P. Specifically, Respondent was asked to describe how he prepared the fentanyl line, to provide an explanation of the items found by C.P. upon her return from meal break, an explanation for the diluted fentanyl bag, and the reason for his repeated access to Patient M.P.'s EMR. Following this initial interview, Respondent was asked to provide a written statement about the events of January 24, 2018.

27. On February 28, 2018, Respondent was interviewed a second time and was asked to demonstrate the steps outlined in his written statement regarding setting up the bag of fentanyl for Patient M.P. on January 24, 2018. During this interview, Respondent ultimately admitted that, "I can't recall every single step. I can't remember every single detail of what I did. The point is, it shouldn't be done that way. I don't normally do it that way." Respondent also admitted that he understood that "a line used for administering fentanyl should not be primed with saline." UCDMC investigators found Respondent's explanations convoluted and the Clinical Management team was consulted regarding Respondent's statements. The investigation concluded that Respondent's explanations were implausible and that Respondent was more likely than not responsible for diverting fentanyl from UCDMC.

Review of Additional Questionable Fentanyl Activity: December 2017 - January 2018

28. UCDMC's detailed review of Respondent's fentanyl activity during the period between December 2017 and January 2018 revealed that Respondent exhibited a pattern of increased administration of fentanyl and oral narcotics when compared to other nurses, as follows:

Patient C.B.

29. Patient C.B. was assigned to Respondent during the shift beginning the evening of January 3, 2018. The patient was on a continuous, standard concentration fentanyl drip, but was switched to a higher concentration fentanyl drip by Respondent at 21:08 after Respondent suggested that a physician resident order the patient a higher concentration fentanyl drip due to

fluid concerns. The resident was unfamiliar with the higher concentration fentanyl, but Respondent assured her that another patient[7] on the unit was on the higher concentration and assisted the resident figuring out how to order it.

30. Once the order was placed, Respondent attempted to access the high concentration solution multiple times (19:25, 19:41, 20:14, and 20:45), using the "cancelled" function, prior to the pharmacy delivering the medication at 21:02 hours. Respondent switched the patient to the high concentration fentanyl drip at 21:08, resulting in inaccurate and significant wastage of the patient's fentanyl. Respondent documented the wastage of 75 mL of standard concentration fentanyl at 21:20.

Patient P.D.

31. Patient P.D. was admitted to UCDMC on November 28, 2017, and assigned to Respondent for shifts beginning the evenings of November 28, 29, and 30 and December 3 and 4, 2017. A general overview of the patient's fentanyl administrations highlights increased fentanyl use during periods when Respondent was assigned as the patient's nurse, as compared to other nurses. Additionally, higher Richmond Agitation Sedation Scale (RASS) scores and positive pain assessments are documented during Respondent's shifts[8]. Respondent also was the only nurse to administer high concentration fentanyl to P.D. during the period for which it had been ordered. Respondent administered 4 mL while documenting wastage of 96 mL.

Patient A.A.

32. Patient A.A. was not assigned to Respondent, but he provided break coverage for the assigned nurse from approximately 03:00 to 04:00 on December 13, 2017. The patient was on continuous drips of morphine for pain and midazolam for agitation. Negative RASS scores were documented consistently before and after Respondent assumed care of the patient. Respondent did not document pain scores or assessments during his coverage, but he did document a RASS

[7] Minutes before the order for Patient C.B. was submitted, Respondent and the resident accessed an order template for a patient with an active order for high concentration fentanyl (Patient P.B.). This patient, assigned to a different nurse, was in the bed adjacent to Patient C.B. and was the only patient in the unit on a high concentration fentanyl drip.

[8] Notably, on December 3, 2017, the patient maintained consistent pain, RASS, and CPOT scores of 0 throughout the day. The value of these assessments increased significantly when Respondent assumed care for the patient at 19:00.

score of +1 at 03:25. Rather than increasing the rate of either established medication, Respondent administered a 0.5 mL (25 mcg) fentanyl injection, indicated for moderate pain, at 03:25. When questioned regarding his actions, Respondent stated, "I'm new and still learning. These are just mistakes, I am not diverting."

Electronic Medical Record (EMR) Scrolling Activity

33. During the course of reviewing Respondent's fentanyl activities, the UCDMC Compliance Department identified multiple dates when Respondent accessed the Electronic Medical Records of patients to whom he was not assigned. As a result, a review of Respondent's January 2018 EMR access was undertaken to ascertain whether his activity within the system was for a discernable work purpose. This review identified a pattern of EMR activity whereby Respondent would "scroll" through numerous patient records during a shift. This scrolling activity consisted of rapid, successive access to the records of patients to whom Respondent was not assigned. The activity focused predominantly on patients' MAR, was identified during five shifts in January 2018, and began once Respondent was assigned to the Surgical Intensive Care Unit (SICU). Respondent's scrolling activity began within the first 35 minutes of these five shifts, and at least two separate instances of scrolling per shift were identified. UCDMC's review of Respondent's EMR access between January 14-29, 2018, revealed that Respondent accessed the EMR of 27 patients without a work purpose or a clinical need.

34. On or about January 29, 2018, UCDMC placed Respondent on investigatory leave. On or about May 1, 2018, Respondent resigned from his position with UCDMC without prior notice, and while the investigation remained pending. Respondent relocated to Texas, where he is currently licensed as a registered nurse.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

35. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in that Respondent was grossly negligent within the meaning of California Code of Regulations, title 16, section 1442, when he departed from the standards of practice related to the administration and documentation of fentanyl, and to his access of patient records

1 without a clinical need, as more particularly set forth above in paragraphs 18 through 33, and
2 incorporated here by reference, and as follows:

3 **January 24, 2018 Incident – Patient M.P.**

4 a. Respondent prematurely spiked a bag of fentanyl for Patient M.P., and rather than
5 wasting it, Respondent acknowledged that he left it unsecured despite knowing it was not
6 intended for immediate use.

7 b. Respondent removed multiple syringes of fentanyl from the fentanyl bag.

8 c. Respondent significantly diluted the fentanyl bag with saline, causing the medication
9 to be approximately 32% of the expected concentration.

10 d. Respondent utilized or intended to utilize several unnecessary medical tools that were
11 discovered in Patient M.P.'s room by C.P. upon her return from a meal break. These
12 irregularities include a 50 or 60 mL luer lock syringe inside the sharps container, several empty
13 normal saline flushes, and several blunt infusion needles scattered in the bed and on the floor.
14 Additionally, C.P. found that green alcohol caps were missing from the injection ports of the
15 current IV fentanyl GTT[9] that was infusing.

16 **Review of Additional Questionable Fentanyl Activity: December 2017 - January 2018**

17 e. Respondent exhibited a problematic pattern of increased administration of fentanyl as
18 compared to other nurses, and demonstrated gross negligence in his treatment of patient A.A.:

19 **Patient A.A.**

20 f. During a break coverage, Respondent administered a fentanyl injection to address the
21 patient's pain despite not having documented a pain score or Care Pain Observation Tool (CPOT)
22 score during his coverage, and instead of increasing the administration rates of the continuous
23 drips of morphine and midazolam already established to address the patient's pain and agitation,
24 respectively.

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27 ///

28 [9] GTT is an abbreviation meaning drops.

Electronic Medical Record (EMR) Scrolling Activity

g. On or between January 14-29, 2018, Respondent accessed the personal health information of at least 27 patients to whom he was not assigned, focusing predominantly on the patients' MAR, without a work purpose or clinical need.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

36. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in that Respondent demonstrated incompetence with respect to his administration and documentation of the controlled substance, fentanyl, and to his access of patient records without a clinical need, as more particularly set forth above in paragraphs 18 through 35, incorporated here by reference, and as follows:

January 24, 2018 Incident – Patient M.P.

a. Respondent accessed Patient M.P.'s EMR without a clinical need.

b. Respondent acquired a bag of fentanyl for Patient M.P. approximately 2.5 hours before the bag was medically necessary.

c. Respondent primed a line with saline for administering a continuous intravenous medication.

Review of Additional Questionable Fentanyl Activity: December 2017 - January 2018

d. Respondent exhibited a problematic pattern of increased administration of fentanyl as compared to other nurses, and demonstrated incompetence in his treatment of patients C.B. and P.D.:

Patient C.B.

e. Respondent's suggestion that a resident transition Patient C.B. to a higher concentration of fentanyl was medically unwarranted and demonstrated Respondent's unnecessary sense of urgency to increase the concentration of the patient's fentanyl solution. The increase resulted in the documented wastage of 75 mL of standard fentanyl solution.

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Patient P.D.

f. Patient P.D.'s records reveal increased fentanyl use during periods when Respondent was assigned as the patient's nurse as compared to other nurses, corresponding with Respondent's documentation of higher RASS and positive pain assessments of the patient. Respondent was the only nurse to administer high concentration fentanyl medication during the order period and administered a minimal amount (4 mL), subsequently documenting a wastage amount of 96 mL, providing Respondent access and an opportunity to divert a significant amount of high concentration fentanyl that he documented as waste.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

37. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraphs 18 through 36, and incorporated here by reference.

FOURTH CAUSE FOR DISCIPLINE

(Diversion, Unlawful Possession, and/or Self-Administration of Controlled Substances)

38. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct as defined in Code section 2762, subdivision (a), in that on or about January 24, 2018, Respondent obtained the controlled substance fentanyl from his place of employment by fraud, deceit, misrepresentation, or subterfuge in violation of Health and Safety Code section 11173, subdivision (a). The circumstances are more particularly set forth above in paragraphs 18 through 37, incorporated here by reference, and as follows:

a. A UCDMC review of Respondent's EMR access between January 14-29, 2018 revealed that Respondent accessed the EMR of twenty-seven (27) patients without a work purpose or a clinical need. Respondent's access to the private health information of patients to whom he was not assigned focused primarily on each patient's MAR, indicating an attempt to gather information about patient medications for diversion.

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b. A UCDMC review of Respondent's fentanyl activities while employed at UCDMC between the period of December, 2017 – January, 2018 illustrates a pattern of problematic behavior related to Respondent's access to and administration of controlled substances, as more particularly set forth above in paragraphs 28-32, and 35-36, incorporated here by reference, and as follows:

c. Respondent suggested that a resident transition Patient C.B. to a higher concentration of fentanyl solution. Despite the resident's unfamiliarity with the higher concentration fentanyl, Respondent assisted the resident with the order, noting that another patient on the unit was receiving the higher concentration fentanyl. Once the order was placed, Respondent made repeated attempts to retrieve the high concentration solution for Patient C.B. from the Pyxis prior to the delivery of the medication. The transition to the rarely used higher concentration fentanyl resulted in the documented wastage of 75 mL of standard fentanyl solution, providing Respondent with access and an opportunity to divert a significant amount of fentanyl solution that he documented as waste.

d. During periods when Respondent was assigned as the nurse for patient P.D., he administered a high concentration fentanyl solution between 21:19 on December 3, 2018 to 6:10 on December 4, 2018. The administration of high concentration fentanyl solution was not supported by the documentation in the patient's record. Respondent was also the only nurse to administer the higher concentration fentanyl solution during the order period. Respondent only administered a minimal amount (4 mL), and subsequently documented a wastage amount of 96 mL, providing Respondent access and an opportunity to divert a significant amount of high concentration fentanyl that he documented as waste.

e. Respondent accessed patient M.P.'s EMR multiple times without a clinical need, including before obtaining a coverage assignment for the patient, and following his coverage of the patient. Respondent's access was focused significantly on the patient's medication administration record and fentanyl orders.

f. During Respondent's evening shift on January 22-23, 2018, prior to learning of his break coverage assignment, and hours prior to assuming care of the patient, Respondent began

viewing M.P.'s MAR, and specifically the patient's fentanyl order. Respondent also asked C.P. about M.P. and expressed his interest in the patient prior to assuming coverage for the patient during C.P.'s break. During this break coverage, Respondent contacted the on-call resident to discuss M.P.'s fentanyl drip and recommended that the resident order a higher concentration fentanyl drip for the patient.

g. During his coverage of patient M.P. on January 24, 2018, Respondent increased the patient's propofol administration rate from 5 mcg per hour (2.3 mL per hour) to 10 mcg per hour (4.5 mL per hour). As a result, M.P. was "pretty out of it" when C.P. returned from her break.

h. Respondent acquired a bag of fentanyl for patient M.P. approximately 2.5 hours before the bag was medically necessary. Although Respondent claimed that he was doing so to be helpful and to ensure the medication did not run out, the fentanyl bottle in use contained approximately 23 mL of fentanyl solution at the time, and Respondent should have visibly recognized that there was no immediate need for a new fentanyl bag. Additionally, C.P. reported that she expressly told Respondent that the bag did not need to be changed during Respondent's coverage of the patient.

i. Respondent spiked the fentanyl bag with new IV tubing rather than setting the bag up with the same IV tubing already established to administer fentanyl to the patient.

j. Respondent removed multiple syringes of fentanyl from the fentanyl bag.

k. Respondent significantly diluted the fentanyl bag with saline, causing the medication to be approximately 32% of the expected concentration.

l. After C.P. notified the charge nurse, P.G. about the incident, Respondent disappeared for approximately 10-15 minutes without requesting break coverage or notifying any other nursing staff of his whereabouts.

m. When confronted by UCDMC regarding the significant dilution of M.P.'s fentanyl bag, Respondent provided explanations that were implausible, in part because they violated clinical practice and contained unnecessary steps.

n. Despite ample opportunities, Respondent was unable to provide credible explanations to account for the condition of the room upon C.P.'s return, including the half-filled 10 cc saline

flush on the patient's bed, the flush cap and two grey needle caps on the floor; a 50 or 60 mL syringe in the sharps container, multiple needle caps, green caps missing from the ports on the patient's active fentanyl drip, and the clamped closed and disconnected antibiotic from the saline line.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 95053436, issued to Larry Stephen Laurent;

2. Ordering Larry Stephen Laurent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: July 21, 2020

[signature] for
LORETTA MELBY, R.N., M.S.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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