STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS, Attorney General, Plaintiff, vs. WICKS, BRANDY, Defendant.	240742 RN FINDINGS OF FACT AND CONCLUSIONS OF LAW; ORDER

STATEMENT OF THE CASE

A Petition for Adverse Action was filed in this matter on June 6, 2024, alleging that Defendant, Brandy Wicks, has engaged in unprofessional conduct and has practiced her profession in a pattern of negligent or incompetent conduct.

SUMMARY OF THE HEARING

A hearing was held in this matter on October 24, 2024, in Lincoln, Nebraska, before Robert E. Harkins, Department of Health and Human Services (DHHS) Hearing Officer. Assistant Attorney General T.J. O'Neill appeared on behalf of the State of Nebraska. Defendant failed to appear. Testimony and exhibits were received into evidence.

The Hearing Officer makes the following proposed Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Proper notice of this hearing was provided to the parties.

2. At all times relevant to this proceeding, Defendant has held a multistate registered nursing license (#153828) issued by the State of Iowa.

3. Nebraska and Iowa are party states to the Nurse Licensure Compact ("Compact"), Neb. Rev. Stat. §§71-1795 and 71-1795.01.

4. Under the provisions of the Nurse Licensure Compact Act, the Defendant's home state nursing license from the State of Iowa authorizes the Defendant to practice nursing in the State of Nebraska, absent "adverse action" by Nebraska affecting the Defendant's privilege to practice nursing in Nebraska.

5. DHHS may discipline the Defendant's multistate licensure privilege to practice nursing in Nebraska in accordance with Nebraska's disciplinary due process laws pursuant to the provisions of the Compact, Neb. Rev. Stat. §§71-1795.01, Article III(d), and Article V(a)(1).

6. From November of 2021 to July 2022, Defendant was employed as a registered nurse by S.C.H., a travelling hospice company in Council Bluffs, Iowa.

7. On or about July 19, 2022, Defendant provided home nursing care for Patient A, who had a new prescription for MS Contin 30 mg, a Schedule II drug containing morphine. After Defendant left, Patient A's spouse noticed the MS Contin was missing and telephoned Defendant. Defendant denied moving the medication, but later returned the medication and stated the medication must have fallen off the table into her bag. Approximately eight (8) tablets were missing from the returned prescription.

8. From May 2023 to July 2023, Defendant was employed as a nurse at Nebraska Medicine in Omaha, Nebraska.

9. On or about June 23, 2023, at approximately 0353 hours, Defendant removed Oxycodone, a Schedule II Controlled Substance, from the automated medication dispensing system (Omnicell) for Patient B. Defendant updated Patient B's medical chart to show the Oxycodone was administered to Patient B; however, Patient B later reported to Defendant's co-worker at around 7:00 a.m. that the last dose of Oxycodone had been received at midnight.

10. On or about June 27, 2023, Nebraska Medicine suspended Defendant and initiated a controlled substances audit for the months of May and June 2023.

11. The audit revealed that over fifteen (15) days between May 20, 2023 and June 21, 2023, there were more than fifty-two (52) discrepancies between the Omnicell and medication administration records (MARs) for seventeen (17) patients involving Schedule II Controlled Substances for care provided by Defendant. Discrepancies included Defendant charting the administration of controlled substances before removal of the controlled substances from the Omnicell on at least nineteen (19) occasions, administering controlled substances between thirty minutes and more than one hour after dispensing from the Omnicell at least twenty six (26) occasions, and Defendant wasted unused controlled substances more than one hour after removal from the Omnicell on at least two (2) occasions. In addition, Defendant charted controlled substances as administered in Patients' MARs more than thirty (30) minutes after medication administration at least (12) times, and Defendant charted Patients' pain scores more than thirty minutes after administration of medication at least ten (10) times.

12. All the discrepancies described in Paragraph 11 directly violated in place Nebraska Medicine Policies and Procedures regarding, inter alia, medication security and storage, controlled substance management, and medication administration.

13. On or about July 3, 2023, Nebraska Medicine terminated Defendant's employment based on failure to follow policies and procedures relating to controlled substances administration.

14. On or about February 29, 2024, a DHHS Investigator interviewed Defendant. Defendant denied she documented administration of controlled substances before removing same from Omnicell and denied diverting controlled substances for her own use. Defendant admitted that while she was Lead Nurse she would pull all controlled substances and non-controlled medications from the Omnicell and place them in the patients' drawers for administration at a later time. Defendant conceded this was against Nebraska Medicine policy. Finally, Defendant offered no explanation for the discrepancies in controlled substance administration times and delays in charting controlled substance administration in the Patients' MARs.

15. Defendant failed to appear at the administrative hearing.

CONCLUSIONS OF LAW

Jurisdiction is based upon Neb. Rev. Stat. §§38-176, 38-186, 71-1795, and 71-1795.01. A credential to practice may be disciplined for "Practice of the profession... (d) in a pattern of incompetent or negligent conduct;" and for "unprofessional conduct as defined in section 38-179." Neb. Rev. Stat. §38-178(6)(d) and (24).

Unprofessional conduct means "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, including, but not limited to..."(10) failure to keep and maintain adequate records of treatment or service...; and (17) such other acts as may be defined in rules and regulations." Neb. Rev. Stat. §38-179. Applicable regulations define unprofessional conduct to include "failure to follow policies or procedures implemented in the practice situation to safeguard patient care." 172 NAC 101-006(3).

Pursuant to the Compact, all party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation, or any other action that affects a nurse's authorization to practice under a multistate licensure privilege. Neb. Rev. Stat. §71-1795.01, Article III(d).

The State proved by clear and convincing evidence that Defendant engaged in

unprofessional conduct by repeatedly violating facility policies regarding proper medication dispensing and administration and by failing to keep and maintain adequate records of treatment or service. The State also showed by clear and convincing evidence that Defendant's conduct as described in paragraphs 7, 9, and 11 above constituted practice of her profession in a systematic pattern of incompetent or negligent conduct. All of Defendant's actions and inactions constitute grounds for discipline.

Upon the completion of any hearing held regarding discipline of a credential, the director may dismiss the action or impose any of the following sanctions: (1) Censure; (2) Probation; (3) Limitation; (4) Civil penalty; (5) Suspension; or (6) Revocation. Neb. Rev. Stat. §38-196. If a credential holder fails to appear at their hearing after proper notice, the Chief Medical Officer "shall order the credential revoked or suspended or shall take any or all of the other appropriate disciplinary measures authorized by section 38-196 against the credential." Neb. Rev. Stat. §38-191.

Defendant's actions are serious and constitute a significant risk to public safety. Defendant has abused the privilege to practice nursing in Nebraska that she has been graciously granted under the Compact. In addition, defendant's failure to appear at the administrative hearing shows she has no interest in submitting to the regulatory authority of DHHS or to maintain her privilege to practice nursing in the State of Nebraska. A significant sanction is necessary to adequately protect the safety of Nebraska citizens and to deter others from similar conduct. Based on the evidence presented and in consideration of the underlying facts and circumstances, Defendant's privilege to practice nursing in the State of Nebraska pursuant to the Compact should be revoked.

ORDER

Based upon the foregoing proposed Findings of Fact and Conclusions of Law, I recommend that the Defendant's privilege to practice as a Registered Nurse in the State of Nebraska pursuant to the Nurse Licensure Compact be REVOKED, effective ten (10) days from the date this Order is adopted by the Chief Medical Officer.

Date: 10/30/24

[redacted]
Robert E. Harkins, Hearing Officer

I hereby adopt the foregoing proposed Findings of Fact and Conclusions of Law and recommended Order in the above captioned proceedings as my official and final Order.

IT IS SO ORDERED.

Date: OCT 30, 2024

[redacted]
Timothy Tesmer, MD
Chief Medical Officer
Division of Public Health
Department of Health and Human Services

NOTICE

Pursuant to the Administrative Procedure Act, NEB. REV. STAT. § 84-901 *et seq.*, this decision may be appealed by filing a petition in the district court of the county where the action is taken within thirty days after the service of the final decision by the agency.

CERTIFICATE OF SERVICE

The undersigned certifies that a copy of the foregoing was sent on the date below by United States Mail, postage prepaid, and/or electronically to the following:

BRANDY WICKS 603 HILLCREST AVE COUNCIL BLUFFS IA 51503
THOMAS O'NEILL ASSISTANT ATTORNEY GENERAL AGO.HEALTH@NEBRASKA.GOV

Date: 10/30/24

[redacted]
DHHS Hearing Office
P.O. Box 98914
Lincoln, NE 68509-8914
P. (402) 471-7237 F. (402) 742-2374
dhhs.hearingoffice@nebraska.gov

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS Attorney General,	)	
Plaintiff,	)	**PETITION FOR ADVERSE ACTION: NURSE LICENSURE COMPACT**
vs.	)	
BRANDY J. WICKS, R.N.,	)	
Defendant.	)	

The Plaintiff alleges as follows:

JURISDICTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 38-176 (Reissue 2016) and 38-186 (Cum. Supp. 2022).

2. At all times relevant herein, The Defendant, Brandy J. Wicks, R.N.., has been the holder of a multi-state registered nursing license (#153828) issued by the State of Iowa.

3. Nebraska and Iowa are party states to the Nurse Licensure Compact, Neb. Rev. Stat. § 71-1795.01 (Reissue 2018).

4. Under the provisions of Nurse Licensure Compact Act, the Defendant's home state has been Iowa.

5. Pursuant to the provisions of the Nurse Licensure Compact Act, the Defendant's home state nursing license from the State of Iowa authorizes the Defendant to practice nursing in Nebraska, absent "adverse action" by Nebraska affecting the Defendant's privilege to practice nursing in Nebraska.

6. The Nebraska Department of Health and Human Services ("Department") is the agency of the State of Nebraska authorized to enforce the provisions of the Uniform Credentialing Act regulating the practice of nursing.

7. The Department may discipline the Defendant's multi-state licensure privilege to practice nursing in Nebraska in accordance with Nebraska's disciplinary due process laws pursuant to the provisions of the Nurse Licensure Compact, Neb. Rev. Stat. § 71-1795.01, Article III(d), and Article V(a)(1) (Reissue 2018).

8. The Nebraska Board of Nursing has considered the investigation of this matter and made a recommendation to the Attorney General to file disciplinary proceedings against the Defendant's privilege to practice nursing in the State of Nebraska under the Nurse Licensure Compact.

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

9. From approximately November 2021 to July 2022, the Defendant was employed as a registered nurse at S.C.H., a traveling hospice company, located in Council Bluffs, Iowa.

10. On or about July 19, 2022, the Defendant attended a home visit for Patient A. Patient A had a new prescription for MS Contin 30mg: a schedule II drug containing morphine. After the Defendant left, the spouse of Patient A noticed the new prescription was missing. The spouse called the Defendant, who denied moving the prescription. Later, the Defendant returned the medication stating it must have flipped off the table into her bag. Approximately eight pills were missing from Patient A's prescription upon return.

11. From approximately May 2023 to July 2023, the Defendant worked as a registered nurse in the trauma center at N.M., located in Omaha, Nebraska.

12. On or about June 23, 2023, at approximately 03:53 a.m., the Defendant removed Oxycodone, a schedule II controlled substance, from the Omnicell (the medication automated dispensing cabinet) for Patient B.

13. At approximately 6:25 a.m., Co-Worker A also removed Oxycodone from the Omnicell for Patient B. Patient B's medical record did not show the Defendant's 3:53 a.m. Oxycodone administration at approximately 6:25 a.m. when Co-Worker A checked.

14. At approximately 7:00 a.m., Co-Worker A went to Patient B's room to administer the Oxycodone, at which point Patient B's medical record had been updated to include the alleged 3:53 a.m. Oxycodone administration by the Defendant. When Co-Worker A asked Patient B if the last dose of Oxycodone Patient B received was at midnight, administered by Co-Worker A, Patient B stated "that is correct."

15. On approximately June 27, 2023, N.M. suspended the Defendant and ran an internal controlled substances audit for the months of May and June, 2023.

16. Over fifteen (15) days between May 20, 2023 and June 21, 2023, there were more than fifty-two (52) discrepancies between the Omnicell and medication administration records (MARs) for seventeen (17) patients involving schedule II controlled substances for care provided by the Defendant. Discrepancies include the following:

a. The Defendant charted controlled substances as administered prior to the controlled substances' removal from the Omnicell at least nineteen (19) times;

b. The Defendant administered controlled substances more than thirty minutes but less than one hour after removal from the Omnicell at least thirteen (13) times;

c. The Defendant administered controlled substances more than one hour after removal from the Omnicell at least thirteen (13) times;

d. The Defendant wasted unused controlled substances more than one hour after removal from the Omnicell at least two (2) times;

e. The Defendant charted controlled substances as administered in the Patients' MARs more than thirty (30) minutes after medication administration at least twelve (12) times; and

f. The Defendant charted Patients' pain scores more than thirty minutes after administration of medication at least ten (10) times;

17. On or about July 3, 2023, the Defendant's employment was terminated by N.M. based on failure to follow policies, procedures, and practices pertaining to controlled substance administration. Areas of concern included failure to document in real-time; pulling controlled substances from the Omnicell without justification; inaccurate charting of administration times; and having an excessive number of pain medication administration compared to other staff caring for the patient prior to or following the Defendant's shift.

18. On or about February 29, 2024, the Defendant was interviewed by a Department Investigator. During the interview:

a. The Defendant denied documenting that she administered controlled substance medications prior to removing them from the Omnicell;

b. The Defendant stated that while she was Lead Nurse, she would pull all controlled substance and non-controlled substance medications from the Omnicell and place them in the patients' drawers for administration at a later time. She was aware this was against policy;

c. Regarding hours elapsed between removing and wasting controlled substances, the Defendant stated she most

likely put the controlled substance in her pocket and forgot about it until she reached in her pocket for something else, at which time she wasted the controlled substance;

d. The Defendant denied diverting controlled substances for personal use; and

e. The Defendant did not explain the discrepancies in controlled substance administration times and delays in charting the controlled substance administration in the Patients' MARs.

19. N.M. had the following policies and procedures in place at the time of the Defendant's employment:

a. Medication Security and Storage:

i. "All controlled substances must be stored in locked storage areas. Controlled substances will be stored in an automated dispensing cabinet (ADC) when available...."

b. Medication Management Electronic Barcode Medication Procedure:

i. Step 2: "Review the patient's MAR...."

ii. Step 3: "Gather medications or nutritional products for one patient at a time and administration supplies."

iii. Step 6: "Scan first medication or nutritional product..."

iv. Step 12: "Administer medication(s) or nutritional products to the patient."

v. Step 13: "For each medication or nutritional product administered, verify the documentation appears on the MAR (i.e., administration time, initials and action, etc.)."

c. Nursing Controlled Substance Management Policy:

i. Waste of Controlled Substances: "If wasting is required, waste should occur immediately upon removal from the ADC. Exceptions include: emergent situations and bedside procedures."

ii. Controlled Substance Documentation and Reports: "Administration and documentation of controlled substances should occur immediately following removal from the ADC...."

d. Nursing Medication Administration Procedure:
   i. Preparing and Administering Medications: "Medications removed from a storage area should be removed just prior to administration and for only one patient at a time."

   ii. Monitoring and Evaluation: "For medications given on an as needed (PRN) basis, the nurse assesses and documents the need for and response to the medication."

e. Nursing Medication Automated Dispensing Cabinet and Profile Guidelines:

   i. Documentation: "All medications removed from ADC and administered, withheld, etc. to the patient must be documented in the patient's medical record."

f. Controlled Substance Management Policy:

   i. Wasting Medications: "If part of a controlled substance is to be administered, the waste must be documented at the ADC at the time of removal by using the Waste option. This transaction must be witnessed by another healthcare provider."

FIRST CAUSE OF ACTION

20. Paragraphs 1 through 19 are incorporated herein by reference.

21. Neb. Rev. Stat. § 38-178(6) (Cum. Supp. 2022) provides that a professional license may be disciplined for practice of the profession (d) in a pattern of incompetent or negligent conduct.

22. The Defendant's conduct as outlined in Paragraph 16 above is grounds for discipline.

SECOND CAUSE OF ACTION

23. Paragraphs 1 through 19 are incorporated herein by reference.

24. Neb. Rev. Stat. § 38-178(24) (Cum. Supp. 2020) provides that a professional license may be disciplined for any unprofessional conduct as defined in section 38-179.

25. Neb. Rev. Stat. §38-179 (Cum. Supp. 2022) defines unprofessional conduct as "...any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, include, but not limited to:...(10) failure to keep and maintain adequate records of treatment or service."

26. The Defendant's conduct as outlined above constitutes multiple grounds for discipline.

THIRD CAUSE OF ACTION

27. Paragraphs 1 through 19 are incorporated herein by reference.

28. Neb. Rev. Stat. § 38-178(24) (Cum. Supp. 2020) provides that a professional license may be disciplined for any unprofessional conduct as defined in section 38-179.

29. Neb. Rev. Stat. §38-179 (Cum. Supp. 2022) defines unprofessional conduct as "...any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, include, but not limited to:...(15) such other acts as may be defined in rules and regulations."

30. 172 NAC 101.006, governing the practice of nursing, defines unprofessional conduct as (3) failure to follow policies or procedures implemented in the practice of nursing to safeguard patient care.

31. The Defendant's conduct as outlined above constitutes multiple grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Chief Medical Officer set this matter for hearing, order appropriate disciplinary action pursuant to Neb. Rev. Stat. § 38-196 (Reissue 2016) and tax the costs of this action to the Defendant.

(SIGNATURES ON FOLLOWING PAGE)

STATE OF NEBRASKA, ex rel.
MICHAEL T. HILGERS, Attorney General,
Plaintiff,

BY: MICHAEL T. HILGERS, #24483
Attorney General

BY: [redacted]
Thomas J. O'Neill III, #25407
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509-8920
(402) 471-3818

Attorneys for the Plaintiff.