BEFORE THE INDIANA STATE BOARD OF NURSING
CAUSE NUMBER: 2017 NB 0103

IN THE MATTER OF THE LICENSE OF:)
)
DARRELL LYNN SCROGHAM II, R.N.)
)
LICENSE NO: 28218013A (Active))

ADMINISTRATIVE COMPLAINT

The State of Indiana ("Petitioner"), by counsel, Natalie R. Stidd, Deputy Attorney General, on behalf of the Office of the Indiana Attorney General, and pursuant to Ind. Code § 25-1-7-7, Ind. Code ch. 25-1-5, Ind. Code § 25-23-1-7, the Administrative Orders and Procedures Act, Ind. Code ch. 4-21.5-3, and Ind. Code ch. 25-1-9, files its Administrative Complaint against the Indiana nursing license of Darrell Lynn Scrogham II, R.N. ("Respondent"), before the Indiana State Board of Nursing ("Board") and, in support, alleges and states the following:

FACTS

1. Respondent is a Registered Nurse ("RN") in the State of Indiana having been issued license number 28218013A on August 11, 2014. From February 17, 2000 until its expiration on October 31, 2014, Respondent was licensed as a practical nurse under license number 27047793A.

2. Respondent's address on file with the Indiana Professional Licensing Agency ("IPLA") is 4671 Grand Haven Lane #A, Indianapolis, Indiana.

3. Respondent was hired as a RN by Genesis HealthCare ("Genesis") on or about September 29, 2015. Respondent was employed at Genesis' Decatur Township Center.

4. On January 4, 2016, Respondent received an Individual Performance Improvement Plan-Counseling Only-Non-Disciplinary for "unsatisfactory job performance,"

related to an incident with a resident's family member on January 3, 2016. The resident's family member had alleged that Respondent was rude and unprofessional in speaking with her as to why the resident was in the dining room and not being fed in the resident's room.

5. On February 1, 2016, Respondent received an Individual Performance Improvement Plan-First Counseling for "unsatisfactory job performance," related to Respondent's "failure to discontinue old orders resulting in medication errors," which took place on January 28, 2016.

6. On February 11, 2016, at a 6:00 p.m. shift change narcotics count, Respondent counted only twenty-five (25) Morphine IR 30 mg tablets, when there should have been twenty-nine (29) tablets for Patient R.L. Respondent was the only licensed nurse to have access to the narcotics from the last correct count at 6:00 a.m.

7. Respondent documented and initialed on Patient R.L.'s Medication Administration Record ("MAR") that two tablets of Morphine IR 30 mg had been dropped at 12:00 p.m. The initials "D.O." appear beside Respondent's entry on the MAR, indicating that nurse Debra Oliver ("Oliver") witnessed the drop of these pills. In actuality, Oliver did not witness Respondent waste the two dropped pills, and she did not place her initials next to the relevant entry on the MAR of Patient R.L.

8. Below the MAR entry regarding the dropped pills, Respondent documented "corrected" and circled twenty-five (25) as the tablet count. This MAR entry has no co-signature or witness initials.

9. Patient R.L. had signed himself out on leave from the Decatur Township Center at 11:00 a.m. on February 11, 2016. Prior to Patient R.L. signing himself out, Respondent

packaged up medication for Patient R.L. to take with him, but Respondent did not document having done so.

10. On February 12, 2016 at 7:27 a.m., Respondent notified Christie Witty, R.N., Director of Nursing Services ("DNS Witty") that two pills of Morphine IR 30 mg were missing from the medication cart. DNS Witty initiated an investigation on the same date.

11. DNS Witty reviewed the MAR for Patient R.L. and determined that the initials "D.O." next to the entry regarding the two dropped pills were indicated that Oliver had witnesses the wastage.

12. On February 12, 2016, Genesis placed Respondent on investigative leave.

13. In a February 16, 2016 interview, Respondent admitted to DNS Witty that he was not signing out narcotic medication at the time he administered them. Respondent admitted that he was signing out the narcotic medication at the end of "pill pass."

14. On February 19, 2016, Respondent's employment was terminated by Genesis for "Serious violations of Clinical Protocols; and Failure to immediately report abuse, neglect or misappropriation of property; and Falsification of patient medical records." The termination was made telephonically, as Respondent had cancelled the in-person meeting.

VIOLATIONS

15. By falsifying Oliver's initials on Patient R.L.'s MAR, intending to make it appear that Oliver had witnessed Respondent dropping/wasting two tablets of Morphine IR 30 mg, Respondent falsified documentation of nursing actions on the official patient/client record, which is unprofessional conduct pursuant to 848 IAC 2-2-3(6). As such, Respondent knowingly violated a state statute or rule, or federal statute or regulation, regulating his profession, and is subject to disciplinary sanctions pursuant to Ind. Code § 25-1-9-4(a)(3).

16. By failing to document that he had packaged up Patient R.L.'s medication when Patient R.L. signed himself out, Respondent falsified or omitted documentation of nursing actions on the official patient/client record, which is unprofessional conduct pursuant to 848 IAC 2-2-3(6). As such, Respondent knowingly violated a state statute or rule, or federal statute or regulation, governing his profession, and is subject to disciplinary sanctions pursuant to Ind. Code § 25-1-9-4(a)(3).

17. By failing to sign out narcotic medications at the time he administered them, and instead signing them out after the pill pass, Respondent failed to communicate, collaborate, and function with other members of the health care team in violation of 848 IAC 2-2-2(3), and exercised unsafe judgment in his nursing behaviors, thereby failing to meet the minimal standards of acceptable and prevailing nursing practice which could jeopardize the health, safety and welfare of the public, in violation of 848 IAC 2-2-3(1). As such, Respondent knowingly violated a state statute or rule, or federal statute or regulation, governing his profession, and is subject to disciplinary sanctions pursuant to Ind. Code § 25-1-9-4(a)(3).

ACCORDINGLY, Petitioner demands the Board enter an order finding that:

1. Respondent is subject to discipline according to Ind. Code ch. 25-1-9;
2. Imposes the appropriate disciplinary sanctions pursuant to Ind. Code § 25-1-9-9;
3. Directs Respondent to immediately pay all costs incurred in the prosecution of this case, including a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund pursuant to Ind. Code § 4-6-14-10(b), and;
4. Provides any further relief as the Board deems just and proper in the premises.

Respectfully submitted,
CURTIS T. HILL, JR.,
Attorney General of Indiana
Atty. No.: 13999-20

By: Natalie R. Stidd
Natalie R. Stidd,
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CERTIFICATE OF SERVICE

I hereby certify that on the **12th** day of **April**, **2017**, a true and correct copy of the "Administrative Complaint" was served on the following party via First Class U.S. Mail, postage prepaid.

Darrell L. Scrogham, II
4671 Grand Haven Lane #A
Indianapolis, IN 46280

By: Natalie R. Stidd
Natalie R. Stidd
Deputy Attorney General
Attorney No. 28081-55