STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF NURSING
DISCIPLINARY SUBCOMMITTEE

In the Matter of

RANA AWAD HOLMAN, R.N.
License No. 47-04-275763,

File No. 47-19-001276

Respondent.

ORDER OF SUMMARY SUSPENSION

The Department filed an *Administrative Complaint* against Respondent as provided by the Public Health Code, MCL 333.1101 *et seq*, the rules promulgated under the Code, and the Administrative Procedures Act, MCL 24.201 *et seq*.

After careful consideration and after consultation with the Chairperson of the Board of Nursing pursuant to MCL 333.16233(5), the Department finds that the public health, safety, and welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's license to practice as a registered nurse in the state of Michigan is SUMMARILY SUSPENDED, commencing the date this *Order* is served.

Under Mich Admin Code, R 792.10702, Respondent may petition for the dissolution of this *Order* by filing a document clearly titled **Petition for Dissolution of Summary Suspension** with the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 8-29-19

for

By: Cheryl Wykoff Pezon, Director
Bureau of Professional Licensing

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ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs, by Cheryl Wykoff Pezon, Director, Bureau of Professional Licensing, complains against Respondent Rana Awad Holman, R.N. as follows:

1. The Michigan Board of Nursing is an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.* Pursuant to MCL 333.16226, the Board's Disciplinary Subcommittee (DSC) is empowered to discipline licensees for violations of the Public Health Code.

2. Respondent holds a Michigan license to practice as a registered nurse.

3. After consultation with the Board Chairperson, the Department found that the public health, safety, and welfare requires emergency action. Therefore, pursuant to MCL 333.16233(5), the Department summarily suspended Respondent's license to practice as a registered nurse in the state of Michigan, effective upon service of the accompanying *Order of Summary Suspension*.

4. Hydromorphone (e.g., Dilaudid) is a frequently diverted and abused opioid schedule 2 controlled substance.

5. Ketorolac (e.g., Toradol) is a prescription-only nonsteroidal anti-inflammatory drug used to treat inflammation and pain.

6. For historical purposes, the following events occurred:

   a. On March 4, 2015, the Department executed an Administrative Complaint against Respondent based on information she withdrew a hydromorphone tablet for a hospital patient without a physician's order and failed to document the administration or waste of the medication.

   b. On March 3, 2016, in resolution of the Complaint, the Board's Disciplinary Subcommittee executed a Consent Order and Stipulation which placed Respondent on probation for a period of one year. Terms of probation included employer reports, an evaluation by the Health Professional Recovery Program, and continuing education in the areas of disciplinary actions, professional and legal liability, and understanding substance use disorder in nursing. The Order also fined Respondent $500.00.

7. On August 14, 2019, a staff member from Fountain View Surgery Center (facility) in Southfield, Michigan, reported to the Department that Respondent was caught diverting pre-filled syringes of hydromorphone and had confessed to replacing the stolen hydromorphone syringes with syringes filled with ketorolac. The facility feared for patient safety and was concerned that Respondent had obtained the ketorolac syringes from another medical facility based on the syringes' packaging and lot numbers.

8. Based on the facility's report, the Department initiated an investigation.

Department's investigation

9. On April 4, 2019, Respondent began working at Fountain View Surgery Center (facility) located in Southfield, Michigan. Respondent was an agency nurse contracted to work at the facility.

10. On July 31, 2019, facility management provided Respondent with a facility access badge that allowed Respondent access to the facility and its medication room.

11. On August 8, 2019, facility staff noticed that Respondent was present at the facility. However, Respondent was not scheduled to work on August 8, 2019 because the facility did not have any surgeries scheduled.

12. The above incident led facility management to review Respondent's access badge log, and the facility's video surveillance footage. The facility's investigation found the following:

a. On four occasions in early August 2019, Respondent entered the facility and its medication room on days Respondent was not scheduled to work because the facility did not have any surgeries scheduled.

b. Facility staff watched surveillance footage from the above dates and in each instance, saw Respondent enter the building, enter the medication room, and access the narcotics cabinet. On one occasion, facility staff saw Respondent place a pre-filled hydromorphone syringe in her purse.

c. In each instance, Respondent was in and out of the building in approximately three minutes or less. Respondent wore light blue scrubs, which she wore when working at her other job at Surgeon's Choice Medical Center, located in Southfield, Michigan.

13. After reviewing the surveillance footage, facility staff inventoried its supply of pre-filled hydromorphone syringes and found that 23 syringes appeared to have been tampered with. The facility's syringes came in packaging with lot number 6400429. Packaging for six syringes in the supply had a lot number of 6400248.

14. Surgeon's Choice Medical Center used syringes with packaging that had lot numbers of 6400248 and 6400249.

15. According to the facility's review, 16 patients received medication from the stock of syringes that Respondent had stolen from. These patients complained of uncontrollable pain associated with their procedures.

16. On August 9, 2019, Respondent confessed to a coworker at the facility that she diverted hydromorphone from the facility and replaced the hydromorphone with ketorolac.

17. Facility staff subsequently reported the matter to the Department and law enforcement. Respondent's employment with the staffing agency and her contract with the facility were also terminated.

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, or a condition, conduct, or practice that impairs, or may impair, the ability safely and skillfully to engage in the practice of the health profession in violation of MCL 333.16221(a).

COUNT II

Respondent's conduct fails to conform to minimal standards of acceptable, prevailing practice for the health profession in violation of MCL 333.16221(b)(i).

COUNT III

Respondent's conduct demonstrates Respondent's lack of a "propensity . . . to serve the public in the licensed area in a fair, honest, and open manner," MCL 338.41(1), and accordingly a lack of "good moral character," in violation of MCL 333.16221(b)(vi).

COUNT IV

Respondent's conduct constitutes obtaining, possessing, or attempting to obtain or possess a controlled substance or drug without lawful authority, and/or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of MCL 333.16221(c)(iv).

RESPONDENT IS NOTIFIED that, pursuant to MCL 333.16231(8), Respondent has 30 days from the date of receipt of this Complaint to answer it in writing and to show compliance with all lawful requirements for retention of the license. Respondent shall submit the written answer to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, MI 48909.

Respondent's failure to submit an answer within 30 days is an admission of all Complaint allegations. If Respondent fails to answer, the Department shall transmit this complaint directly to the Board's Disciplinary Subcommittee to impose a sanction pursuant to MCL 333.16231(9).

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 8-29-19

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By: Cheryl Wykoff Pezon, Director
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