BEFORE THE VIRGINIA BOARD OF NURSING

IN RE:

HEATHER LOU PALMER, L.P.N.

License Number: 0002-067271 Case Number: 173967 and 177236

RATIFICATION AND ORDER

On July 19, 2017, a panel of the Board met to receive and act upon the Recommended Decision of the

Agency Subordinate. Heather Lou Palmer, L.P.N., was not present nor was she represented by legal counsel.

In consideration whereof, the Board of Nursing ACCEPTS the attached Recommended Findings of Fact

and Conclusions of Law of the Agency Subordinate and ADOPTS the Recommended Order in its entirety.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of

the Department of Health Professions as a public record, and shall be made available for public inspection and

copying upon request.

Pursuant to Virginia Code § 54.1-2400.2(K), the Board considered whether to disclose or not disclose

Ms. Palmer's health records or health services.

Since Ms. Palmer failed to appear at the informal conference, this Order shall be considered final. Ms.

Palmer has the right to appeal this Order directly to the appropriate Virginia circuit court. As provided by Rule

2A:2 of the Supreme Court of Virginia, Ms. Palmer has thirty days from the date of service (the date she

actually received this decision or the date it was mailed to her, whichever occurred first) within which to appeal

this decision by filing a Notice of Appeal with NAME, Executive Director, Board of Nursing, at Perimeter

Center, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233. In the event that this decision is served by

mail, three days are added to that period.

Jay Douglas, M.S.M, R.N., C.S.A.C., F.R.E.

Executive Director

Virginia Board of Nursing

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Virginia Board Of Nursing

ENTERED AND MAILED ON:

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REPORT AND RECOMMENDATION OF AGENCY SUBORDINATE

Jurisdiction and Procedural History

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), Jane Elliott, R.N., Ph.D., serving as Agency

Subordinate of the Virginia Board of Nursing ("Board"), held an informal conference on April 20, 2017 in

Henrico County, Virginia, to inquire into evidence that Heather Lou Palmer, L.P.N., may have violated certain

laws and regulations governing the practice of nursing in the Commonwealth of Virginia.

Ms. Palmer did not appear at this proceeding and was not represented by legal counsel.

Upon consideration of the evidence, the Agency Subordinate makes the following Findings of Fact and

Conclusions of Law and recommends that the Board adopt the following Order.

Notice

By letter dated March 20, 2017, the Board sent a Notice of Informal Conference ("Notice") to Ms.

Palmer notifying her that an informal conference would be held on April 20, 2017. The Notice was sent by

certified and first class mail to the legal address of record on file with the Board. The Notice sent by certified

mail was accepted by Ms. Palmer on March 21, 2017 The Notice sent by first class mail was not returned to the

Board office. Accordingly, the Agency Subordinate concluded that adequate notice was provided to Ms. Palmer

and the informal conference proceeded in her absence.

Recommended Findings of Fact and Conclusions of Law

Heather Lou Palmer, L.P.N., was issued License Number 0002-067271 to practice practical 1.

nursing on October 3, 2003, which is scheduled to expire on March 31, 2018. At all times relevant to the

findings herein, said license was in full force and effect. Her primary state of residence is Virginia.

Ms. Palmer violated Virginia Code § 54.1-3007(2), (5), (6) and (8) and 18 VAC 90-20-2.

300(A)(2)(c) and (e) of the Regulations Governing the Practice of Nursing (currently found at 18 VAC 90-19-

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230(A)(2)(c) and (e), effective February 24, 2017), in that during the course of her employment with The Hidenwood Retirement Community, Newport News, Virginia, she diverted narcotic medications for her own personal and unauthorized use, as evidenced by the following:

- a. On March 19, 2016, March 20, 2016, and March 22, 2016, Ms. Palmer documented that she removed 1 tablet of hydrocodone-acetaminophen 5mg-325mg (C-II) on the Controlled Medication Utilization Record ("CMUR") for Resident A, but failed to document administration of the medication in the resident's Medication Administration Record ("MAR").
- b. On January 24, 2016, January 25, 2016, and February 18, 2016, Ms. Palmer documented that she removed 1 tablet of hydrocodone-acetaminophen on the CMUR for Resident B, but failed to document administration of the medications on the resident's MAR. Further, on February 16, 2016, February 17, 2016, and February 19, 2016, she documented that she removed 1 tablet of hydrocodone-acetaminophen on the CMUR for Resident B at 0600, but documented that she administered the medications on the resident's MAR at 0326, 0322, and 0409 respectively, approximately 2 3 hours prior to the time she documented removing the medications.
- c. On February 18, 2016, Ms. Palmer documented that she removed 1 tablet of lorazepam (C-IV) on the CMUR for Resident C, but failed to document the administration of the medication on the resident's MAR. Further, on March 4, 2016, and March 6, 2016, Ms. Palmer documented that she administered lorazepam to Resident C at 0357 and 0242, but documented that she removed the medication at 0600, on the CMUR, approximately 2 4 hours after she documented administering the medication to the resident.
- d. On nine occasions between February 13, 2016 and April 1, 2016, Ms. Palmer documented that she removed hydrocodone-acetaminophen 5mg 300mg tablets (C-II) on the CMUR for Resident C, but failed to document the medication on the resident's MAR. Further, on February 16, 2016, February 23, 2016, February 27, 2016, March 4, 2016, and March 6, 2016, Ms. Palmer documented that she administered the medications on the MAR for Resident C at 0326, 0344, 0422, 0657, and 0242 respectively, but documented that she removed the medication at 0600 on the CMUR, approximately 2 4 hours after she documented administering the medication to the resident.

- e. On eight occasions between March 19, 2016, and April 7, 2016, Ms. Palmer documented on the CMUR that she removed 1 tablet of alprazolam 0.25mg (C-IV) for Resident D after 2000, counter to the physician's orders that the medication be administered every morning. Further, Ms. Palmer failed to document the administration of the medication on the resident's MAR.
- f. On April 23, 2016, Ms. Palmer falsely documented the administration of Resident E's morning medications in the resident's MAR, when, in fact, the resident refused her medications.
- 3. On April 25, 2016, Ms. Palmer's employment with Hidenwood Retirement Community was terminated.
- 4. Ms. Palmer violated Virginia Code § 54.1-3007(5) and (6) in that she is unsafe to practice practical nursing due to admitted substance abuse and mental illness, as evidenced by the following:
- a. On October 13, 2016, during the course of her employment with Eastern Virginia Medical School, Internal Medicine/Infectious Disease Clinic, Norfolk, Virginia, Ms. Palmer reported to work in an impaired condition. She was observed slurring her words, looking pale and sweating. A for-cause drug screen was positive for Xanax (alprazolam, C-IV), for which Ms. Palmer did not have a valid prescription.
- b. Ms. Palmer has been abusing multiple controlled medications. She suffers with chronic pain and began abusing her pain medications in 2012, following a fall. Ms. Palmer has worked under the influence of narcotics and hypnotics.
- c. On November 8, 2016, Ms. Palmer was admitted to Riverside Regional Medical Center, Newport News, Virginia, following a suicide attempt. Ms. Palmer was diagnosed with suicidal ideations and major depressive disorder. She was transferred to the Riverside Behavioral Center, and was discharged on November 16, 2016, with a final diagnosis of major depression, severe, recurrent, without psychotic features, opiate use disorder, severe, benzodiazepine use disorder, severe, and substance abuse mood disorder.
- 5. Ms. Palmer stated to the investigator for the Department of Health Professions that she suffers with chronic pain as a result of a fall. She stated that she had current prescriptions for morphine (C-II), oxycodone (C-II), and tizanidine (C-VI). Ms. Palmer stated that she does not attend Alcoholics Anonymous or Narcotics Anonymous.

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6. On October 6, 2016, Ms. Palmer's treatment provider with Bon Secours Neuroscience Center

for Pain Management, Portsmouth, Virginia, recommended that she be discharged from the practice because she

had incorrect medication in a bottle labeled oxycodone. During her previous office visit, Ms. Palmer's pill

count was short.

7. On August 11, 2016, during a psychosocial assessment, Ms. Palmer admitted that she has been

obsessed with death for a couple of years, and the obsession was getting worse. She expressed interest in seeing

"suicide pictures."

8. Pursuant to Virginia Code § 54.1-2400.2(K), the Board considered whether to disclose or not

disclose Ms. Palmer's health records or health services.

Recommended Order

Based on the foregoing Findings of Fact and Conclusions of Law, the Agency Subordinate recommends

that the Board issue an Order as follows:

1. The license issued to Heather Lou Palmer, L.P.N., to practice practical nursing in the

Commonwealth of Virginia is INDEFINITELY SUSPENDED.

2. The license of Ms. Palmer will be recorded as SUSPENDED.

3. This suspension applies to any multistate privilege to practice practical nursing.

4. Should Ms. Palmer seek reinstatement of her license, an administrative proceeding shall be

convened to consider such application. At such time, the burden shall be on Ms. Palmer to demonstrate that she

is safe and competent to return to the practice of nursing. Ms. Palmer shall be responsible for any fees that may

be required for the reinstatement and/or renewal of the license prior to issuance of the license to resume practice.

Reviewed and approved on May 22, 2017

By Jane Elliott, R.N., Ph.D.

Agency Subordinate

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