VIRGINIA:

BEFORE THE BOARD OF NURSING

RE: BONNIE DRAPER TILLER, R.N.

ORDER

Pursuant to § 2.2-4020, § 2.2-4021, § 54.1-110 and § 54.1-2400(11) of the Code of Virginia (1950), as amended (the "Code"), a formal administrative hearing was held before a panel of the Board of Nursing (the "Board") on March 23, 2004, in Henrico County, Virginia, to receive and act upon evidence that Bonnie Draper Tiller, R.N., may have violated certain laws and regulations governing the practice of nursing in Virginia. The case was presented by William C. Garrett, Assistant Attorney General. Howard M. Casway, Senior Assistant Attorney General, was present as legal counsel for the Board. Ms. Tiller was not present and was not represented by legal counsel. The proceedings were recorded by a certified court reporter.

Upon consideration of the evidence presented, the Board adopted the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Bonnie Draper Tiller, R.N., held license number 0001-070677 to practice as a professional nurse in the Commonwealth of Virginia. Said license was summarily suspended by the Board of Nursing on February 13, 2004.

2. Based on Commonwealth's Exhibit 1 and the representations of William C. Garrett, Assistant Attorney General, the presiding officer ruled that adequate notice had been provided to Ms. Tiller and the hearing proceeded in the absence of Ms. Tiller.

3. On February 20, 1999, Ms. Tiller entered into a Participation Contract with the Health Practitioners' Intervention Program ("HPIP"), pursuant to Chapter 25.1 of Title 54.1 of

the Code of Virginia (1950), as amended, and 18 VAC 76-10-10, et. seq., of the Regulations Governing the Health Practitioners' Intervention Program. On May 4, 1999, Ms. Tiller entered into a Recovery Monitoring Contract with the HPIP, acknowledging her opiate dependency. In June 1999, the HPIP Committee granted Ms. Tiller a stay of disciplinary action. Ms. Tiller's stay of disciplinary action was vacated on February 15, 2002.

4. On November 1, 2002, the Board entered an Order taking no action, contingent upon Ms. Tiller's continued compliance with her most recent Recovery Monitoring Contract #5, entered on or about October 16, 2002.

5. On September 15, 2003, Ms. Tiller was dismissed from the HPIP for the following violations:

a. Ms. Tiller violated her HPIP Recovery Monitoring Contract #6, signed by her on July 1, 2003, and received at HPIP on July 29, 2003, by having narcotics access during the course of her employment with Hospice of Central Virginia, Richmond, Virginia;

b. On or about September 2, 2003, Ms. Tiller submitted a positive urine drug screen for fentanyl (Schedule II); and

c. On or about September 1, 2003, Ms. Tiller violated an understanding between herself, HPIP, and her employer, that she was to have no home patient contact by going into a patient's home.

6. By her own admission, on or about January 21, 2004, Ms. Tiller obtained several tablets of Dalmane (flurazepam hydrochloride, Schedule IV) from a friend. On or about January 23, 2004, she ingested them in a suicide attempt.

7. Ms. Tiller diverted narcotics and exhibited drug seeking behavior, as follows:

a. Between approximately November 2003, and January 4, 2004, Ms. Tiller was a frequent visitor to Stratford Hall Nursing Home, Richmond, Virginia, where she was formerly employed.

b. By her own admission, on a date unknown, Ms. Tiller diverted for her own personal and unauthorized use Resident 1's Duragesic patch (fentanyl, Schedule II) by removing it from her chest.

c. By her own admission, on about the afternoon of January 4, 2004, Ms. Tiller attempted to divert Resident 1's Duragesic patch for her own use. Ms. Tiller admits that she adulterated the patch and ingested some of the medication before placing the patch back on Resident 1. However, the nurse that had most recently changed Resident 1's patch stated that the patch did not appear to be the same patch administered before this incident.

d. Resident 1 stated that on the morning of January 4, 2004, Ms. Tiller took her Duragesic patch off her chest and replaced it with another. Resident 1 immediately informed a nurse of Ms. Tiller's activity. The nurse examined Resident 1, finding a pain patch that appeared to be very old and barely attached to the resident's skin.

e. An internal investigation by Stratford Hall after the incidents of January 4, 2004, revealed that Ms. Tiller had been coming to the facility on a regular basis to visit additional residents, including Residents 2 and 3. Specifically:

1) The patients visited were prescribed Duragesic patches.

2) Ms. Tiller's visits would often coincide with the period of time immediately following the residents' schedule for receiving Duragesic patches.

3) Ms. Tiller would approach staff regarding delays in changing the Duragesic patches. These patches were obscured from view by residents' clothing and such information should not have been known to Ms. Tiller. Additionally, Ms. Tiller would volunteer to change the patches for the staff members.

4) On or about December 23, 2003, a nurse observed Ms. Tiller visiting with one of her residents. After Ms. Tiller left the unit, the nurse noted that the resident's Duragesic patch was missing from her back. On or about December 26, 2003, the same nurse again observed Ms. Tiller visiting with the same resident. After Ms. Tiller left, the nurse noted that the Duragesic patch was again missing.

8. During the course of Ms. Tiller's employment with Hospice of Central Virginia, Richmond, Virginia:

a. On or about September 2, 2003, Ms. Tiller submitted a urine drug screen that tested positive for fentanyl but denied that she had used fentanyl on September 1, 2003.

b. By her own admission, Ms. Tiller obtained Adderall (amphetamine and dextroamphetamine mixture, Schedule II) on August 25, 2003, by stealing five tablets of the drug from her daughter's friend. In an attempt to cover up her Adderall use, Ms. Tiller stole urine from the catheter bag of Resident 4, a resident at Imperial Plaza Nursing Home, Richmond, Virginia, and submitted that urine as her own. Resident 4 has not received fentanyl since arriving at the facility, and did not have an order for fentanyl prior to arriving at the facility.

c. Ms. Tiller was terminated from her employment at Hospice of Central Virginia, Richmond, Virginia, on or about October 7, 2003.

9. During the course of her employment as the Director of Nursing with Manor-Care Stratford Hall, Richmond, Virginia, from approximately August 30, 1990, to June 15, 1998:

a. By her own admission, Ms. Tiller diverted "a couple of Vicodin" (hydrocodone bitartrate, Schedule III) for her personal and unauthorized use. Ms. Tiller accomplished this diversion by removing the drugs from medications awaiting destruction at the facility.

b. Ms. Tiller directly involved herself in the ostensible administration of narcotics and collection of narcotics for destruction, although there were clinical nurses available for these tasks. The Administrator was unaware of Ms. Tiller's practice of relocating drugs awaiting destruction to her office until the assistant director of nursing requested that the Administrator check into this procedure. Ms. Tiller's documentation of the destruction of drugs was disorganized at best, and she listed

as witnesses to the destruction of the narcotics nurses who subsequently denied observing Ms. Tiller destroy the drugs. As a result, on or about January 12, 1998, the Administrator sent a memo to all licensed nurses confirming standing policy and instructing that "all narcotics are to be kept under double lock in the medicine room for proper destruction by the consultant pharmacist." The facility's pharmacy consultant was unaware of Ms. Tiller's practice of re-locating drugs awaiting destruction until the January 12, 1998 memo. After this memo was issued, Ms. Tiller continued with the removal of narcotics. Additionally, Ms. Tiller co-signed for the destruction of narcotics with Pharmacist A, a pharmacist with whom she had a personal relationship. Pharmacist A was not the facility's assigned pharmacy consultant, and was not authorized to work at the facility.

c. During the summer of 1997, a corporate supervisor noticed a change in Ms. Tiller's appearance and behavior. Ms. Tiller was eventually confronted and agreed to take a leave of absence to receive treatment. Ms. Tiller was placed on short-term disability leave from December 1997 to February 1998. Ms. Tiller returned to work on February 4, 1998, and, approximately two (2) weeks later, took additional time off for elective surgery.

d. On or about June 2, 1998, Ms. Tiller documented that she borrowed two (2) tablets of Percocet from Resident B for Resident C at noon. One (1) of these tablets was later charted as administered at 5:30 p.m. by an evening nurse, Nurse

D, who reported Ms. Tiller had supplied him with only one (1) tablet for the Resident. Ms. Tiller failed to account for the disposition of the second tablet.

e. Ms. Tiller's employment was terminated in June 1998 due to her breach of medication-related policies.

10. During the course of Ms. Tiller's employment as the Director of Nursing with Parham Healthcare and Rehabilitation Center, Richmond, Virginia, beginning on or about September 16, 1998:

a. Despite numerous resident care issues arising from Department of Health survey visits, Ms. Tiller directly involved herself in the ostensible administration of narcotics and the collection of narcotics for destruction, although there were clinical nurses available for these tasks. Facility policy at that time required that the pharmacist be involved in narcotics destruction. Without the knowledge of the facility's pharmacy consultant, Ms. Tiller instituted a new "security" procedure whereby all drugs awaiting destruction were placed in a locked box inside a padlocked filing cabinet in her nursing office. The padlock opened with a combination that Ms. Tiller had set. Although a key was needed to gain entry to the locked box, Ms. Tiller obtained an extra set of keys for herself, and the key for the locked box was kept in the unlocked desk drawer in the nursing office. Ms. Tiller's documentation of the relocation and destruction of these drugs was at best irregular before November 1998, with dates of transfer and withdrawal records often missing. By Ms. Tiller's own admission, this was a system she had also

previously instituted at Stratford Hall Nursing Center and at Westport Convalescent Center, both of Richmond, Virginia. By Ms. Tiller's own admission, she continued involvement in the administration of narcotics even after she had stated she would stop and a new drug destruction policy was instituted in November 1998 that excluded her from any direct involvement.

b. In September 1998, Ms. Tiller approached Nurse E on her unit, and requested the remainder of the time-release morphine sulfate left after the death of Resident F so that she could destroy the drug. When Nurse E questioned her regarding the destruction policy for these three full cards of morphine tablets, Ms. Tiller assured her the Director of Nursing could destroy drugs by herself. Ms. Tiller then took the drugs and the corresponding sign-outs records with her, without pharmacy participation. There is no documentation of the destruction of these morphine tablets. On or about October 5, 1998, Ms. Tiller again approached Nurse E requesting a resident's morphine cassette, again without pharmacy participation.

c. Resident G held a physician's order for Demerol (meperidine, Schedule II) 25mg injection twice daily, thirty minutes before each dressing change. On September 17, 1998, Ms. Tiller entered an order for Resident G on the MAR for an additional injection of 25mg of Demerol (meperidine, Schedule II) twenty (20) minutes following this first injection, as needed. There is no corresponding physician's order for this notation, and all but one (1) of the corresponding Demerol sign-out records are missing. The one (1) record located reflects Ms. Tiller's withdrawal

on October 6, 1998, of two (2) 50mg vials of Demerol with no wastages recorded, followed by her destruction of the remaining twenty-two (22) vials of Demerol, dated by her as occurring on October 5, 1998. Ms. Tiller charted the administration to the resident of the 50mg of withdrawn Demerol as 25mg at 3 p.m. on October 6, 1998, and 9 a.m. on October 7, 1998.

d. On or about September 17, 1998, a physician ordered Roxicet (morphine sulfate and acetaminophen, Schedule II) one (1) or two (2) tablets by mouth every four (4) hours as needed for pain for Resident H. On or about October 13, 1998, Ms. Tiller took the remaining Roxicet for ostensible destruction and instructed staff to have it discontinued.

e. On one (1) occasion in early October 1998, Ms. Tiller offered to administer medications and was given the narcotic cart keys. The cart was subsequently found open, unlocked and unattended in the hallway, and it appeared that Ms. Tiller had administered only narcotics. When questioned, Ms. Tiller stated she had "gotten busy with something else" and not returned to the medication pass.

f. On or about October 22, 1998, Ms. Tiller approached Nurse I and instructed her to sign out a dose of morphine sulfate for Resident J, who had an order for the drug every two (2) hours as needed. On a separate occasion near the end of October 1998, Ms. Tiller approached Nurse K and instructed her to sign out and chart her administration of morphine sulfate to Resident J. Both nurses did as Ms. Tiller instructed and charted the withdrawal and administration of the doses, since

Ms. Tiller took the morphine sulfate from them without documenting its withdrawal or disposition. In neither case did Ms. Tiller offer to administer the rest of the resident's medications.

g. On or about October 23, 1998, Ms. Tiller instructed staff to have the physician's order for morphine sulfate for Resident L discontinued, and took the tubexes for ostensible destruction in the absence of any recorded physician's instruction or co-signature.

h. On or about October 30, 1998, Ms. Tiller took Resident H's Percocet (oxycodone and acetaminophen, Schedule II) from Nurse M, for ostensible destruction and asked him to have it discontinued. At the end of shift narcotic count, there was no Percocet in the resident's medication supply and no physician's order to discontinue the drug.

i. On or about November 6, 1998, Ms. Tiller instructed staff to have the physician's order for Percocet for Resident G discontinued, and took the forty-six (46) tablets for ostensible destruction in the absence of any recorded physician's instruction or co-signature.

j. Between December 1 and 2, 1998, Ms. Tiller documented the withdrawal of six (6) tablets of Roxicet for Resident N, and the administration of only two (2) tablets to the resident.

k. Between December 15 and 20, 1998, Ms. Tiller documented the withdrawal of seven (7) tablets of Roxicodone (oxycodone HCl, Schedule II) for Resident O, and the administration of only one (1) tablet to the resident.

l. Between December 15 and 20, 1998, Ms. Tiller documented the withdrawal of fourteen (14) tablets of Roxicet (morphine sulfate and acetaminophen, Schedule II) for Resident P, and the administration of only eight (8) tablets to the resident.

m. On or about December 16, 1998, Ms. Tiller charted in Resident Q's nurses' notes that an order was received from an unspecified practitioner, for two (2) tablets of Percocet one (1) time. Ms. Tiller noted administering this dose at 9:45 a.m. in the nurses' notes, but failed to chart this administration on the patient's MAR. Also on this date and for this patient, Ms. Tiller documented the receipt of an order from an unspecified practitioner for Demerol (meperidine, Schedule II) 25mg intramuscularly one (1) time at 12:30 p.m. Ms. Tiller documented in the nurses' notes the administration of Demerol 25mg intramuscularly at 2:50 p.m., but failed to chart this administration on the patient's MAR. Claudia Triplett, R.N., L.N.P., denies that she or Joseph James, M.D., of Richmond, Virginia, authorized this prescription, and states that she explicitly told Ms. Tiller she did not believe the patient should receive Demerol. Roderick Haithcock, M.D., the facility's medical director who eventually co-signed the order, was not the attending physician, has no recollection of discussing the patient with Ms. Tiller, considers his signature to

have been inadvertent, and states that he would not have ordered Demerol in a case such as Resident Q's where there were unexplained injuries.

n. On or about January 1, 1999, Ms. Tiller's employment was suspended when she "borrowed" two (2) tablets of Roxicet (morphine sulfate and acetaminophen, Schedule II) from Resident N on one unit for Resident Q on another unit, in the absence of a physician's order.

o. Ms. Tiller's employment was terminated on or about January 5, 1999, based on her continued administration of medications, failure to follow supervisory instructions to discontinue involvement with narcotics, failure to address various administrative and resident care issues under her purview, and continued suspicions of her diverting drugs.

11. During the course of Ms. Tiller's employment as the Director of Nursing with Fredericksburg Nursing Home, Fredericksburg, Virginia:

a. Between approximately June 2001 and October 2001, Ms. Tiller repeatedly discontinued residents' narcotic medications when staff felt the resident still needed the narcotic, then, often on the same day, Ms. Tiller or staff would have to re-order the narcotic for the residents. This pattern occurred with no fewer than the following patients and drugs on the following dates:

PATIENT	DRUG	ORDERED	D/C DATE	RE-ORDERED	D/C DATE	RE-ORDERED	D/C DATE
R	Duragesic patch (fentanyl,	09/13/01	09/15/01				

	Schedule II),						
S	Endocet (oxycodone, Schedule II),	09/13/01	09/19/01	09/19/01	09/24/01		
T	Morphine (10)	10/01/01	10/02/01				
U	MS Contin (morphine sulfate, Schedule II)	06/09/01	08/19/01				
U	2nd MS Contin (morphine sulfate, Schedule II)	06/21/01	08/20/01	08/20/01	08/24/01	08/24/01	Not d/c'd
V	Hydrocodone	07/19/01	09/11/01	09/11/01	09/12/01	09/12/01	
V	Hydrocodone	10/23/01	01/22/02	01/22/02			
V	Duragesic patch (fentanyl, Schedule II)	07/23/01	09/11/01	09/11/01	09/13/01	09/13/01	Not d/c'd
V	Lorazepam	07/19/01	09/11/01	09/11/01			
V	Methadose	07/23/01	09/11/01	09/11/01	09/12/01	09/12/01	Not d/c'd
V	Methadose	01/09/02	01/11/02	01/11/02	01/22/02	01/23/02	
W	Hydrocodone	09/14/01	09/21/01	09/21/01	10/15/01		
W	2nd Hydrocodone	09/14/01	>>	>>	10/15/01		

X	Hydrocodone	09/05/01	09/06/01	09/06/01	Not d/c'd		
X	Duragesic	09/07/02	09/14/01	09/14/01	10/11/01	10/18/01	
Y	Hydrocodone	08/11/01	08/14/01	08/14/01	09/25/01		
Y	Duragesic	08/14/01	09/05/01	09/05/01	09/19/01	09/19/01	09/25/01

b. Additionally, although the facility administrator had assigned the assistant director of nursing to be responsible for drug destruction after learning of Ms. Tiller's involvement in the HPIP, Ms. Tiller continued to get orders discontinued and to take drugs from the units, ostensibly for destruction. Ms. Tiller's signature appears on disposal records for the following:

RESIDENT	DRUG	DATE DOSES DISPOSED
Z	Tylenol #3	01/24/02
AA	Hydrocodone	01/22/02
V	Hydrocodone	01/22/02
BB	Hydrocodone	01/24/02
BB	Tylenol #3	01/24/02
CC	Oxycontin	01/22/02

c. In approximately early January 2002, by her own admission, Ms. Tiller was observed by Nurse DD, pouring out a measure of liquid morphine sulfate (Schedule II) into a measuring cup. Nurse DD informed Ms. Tiller that pouring the medication out was not necessary, as the bottle was marked, then watched Ms.

Tiller pour the liquid back into the morphine sulfate bottle. However, on another, unspecified date, Ms. Tiller was observed by Nurse EE, pouring out a measure of blue liquid morphine sulfate (Schedule II), and then walking into the medication room for a few moments. Upon Ms. Tiller's return, Nurse EE asked what she was doing and advised her that the bottle was marked for easy counting and that the liquid was not poured out to be counted. Nurse EE observed Ms. Tiller pouring a clear liquid back into the bottle of morphine sulfate. This bottle of Morphine 20mg/5ml (or 4mg/ml) underwent laboratory analysis on or about January 15, 2002, and the contents of the bottle did not meet the manufacturer's specifications in that the concentration of morphine sulfate was determined to be only 1.27mg/ml.

d. On one (1) occasion, a nurse opened the medication cart to obtain morphine sulfate for Resident T, who was frequently in need of pain medication, but the morphine vials were gone. The nurse was told Ms. Tiller had said the morphine sulfate was not being used, so Ms. Tiller ostensibly discontinued the order and destroyed the one (1) opened and nine (9) unopened vials of morphine sulfate. When questioned by the nurse seeking pain relief for the patient, Ms. Tiller told the nurse to call the pharmacy and request more morphine sulfate. However, the nurse was unable to obtain more morphine sulfate from the pharmacy without obtaining a new order from the physician, as the first order had not been discontinued.

12. On January 15, 2004, Ms. Tiller signed a new Participation Contract with the HPIP, which became effective on January 19, 2004. On or about January 29, 2004, Ms. Tiller entered HealthCare Connection of Tampa, Florida.

CONCLUSIONS OF LAW

The Board concludes that:

1. Finding of Fact No. 5 constitutes violation of § 54.1-3007(3) and (6) of the Code.

2. Finding of Fact No. 6 constitutes violation of § 54.1-3007(6) of the Code.

3. Finding of Fact No. 7 constitutes violation of § 54.1-3007(2), (3) and (6) of the Code and 18 VAC 90-20-300(A)(2)(c) and (f) of the Board of Nursing Regulations.

4. Finding of Fact No. 8 constitutes violation of § 54.1-3007(2), (3), (5), and (6) of the Code and 18 VAC 90-20-300(A)(2)(c) and (f) of the Board of Nursing Regulations.

5. Finding of Fact Nos. 9 and 10 constitute violations of § 54.1-3007(2), (3), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) and (e) of the Board of Nursing Regulations.

6. Finding of Fact No. 11 constitutes violation of § 54.1-3007(2), (3), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) of the Board of Nursing Regulations.

ORDER

WHEREFORE, the Virginia Board of Nursing, effective upon entry of this Order, hereby ORDERS that License No. 0001-070677, issued to Bonnie Draper Tiller, R.N., to practice professional nursing in the Commonwealth of Virginia, be and hereby is REVOKED.

Upon entry of this Order, the license of Bonnie Draper Tiller, R.N., will be recorded as

revoked and no longer current. Pursuant to Section 54.1-2408.2 of the Code and consistent with the terms of this Order, in the event that Ms. Tiller seeks reinstatement of her license after a period of three (3) years, she shall be responsible for any fees that may be required for the reinstatement and renewal of her license prior to issuance of her license to resume practice.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as public record and shall be made available for public inspection or copying on request.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Ms. Tiller has thirty (30) days from the service date in which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad Street, Fifth Floor, Richmond, Virginia 23230-1712. The service date shall be defined as the date Ms. Tiller actually received this decision or the date it was mailed to her, whichever occurred first. In the event this decision is served upon her by mail, three (3) days are added to that period.

FOR THE BOARD

Susan Bell Rosen

for Jay P. Douglas, R.N., M.S.M., C.S.A.C.
Executive Director for the
Board of Nursing

April 2, 2004

ENTERED

Certificate of Service

I hereby certify that a certified true copy of the foregoing Order was mailed on this day to Bonnie Draper Tiller at 6433 Lakeway Drive, Mechanicsville, Virginia 23111, and to Bonnie Draper Tiller at c/o HealthCare Connection of Tampa, 825 West Linebaugh Avenue, Tampa, Florida 33612.

for Jay P. Douglas, R.N., M.S.M., C.S.A.C.
Executive Director for the
Board of Nursing

April 2, 2004
DATE

Certified True Copy
By LB 4/2/04
Virginia Board of Nursing