S.

COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Nursing

Nancy K. Durrett, R.N., M.S.N.
Executive Director
nursebd@dhp.state.va.us

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9909
Nurse Aide Registry (804) 662-7310
FAX (804) 662-9512
TDD (804) 662-7197

September 20, 2002

Bonnie Draper Tiller, R.N.
9419 Dogwood Garth Lane
Mechanicsville 23116

CERTIFIED MAIL
7160 3901 9844 7518 4858

RE: License No.: 0001-070677 current to 1/31/04

Dear Ms. Tiller:

This is official notification that an Informal Conference will be held, pursuant to § 2.2-4019, § 2.2-4021, § 54.1-2400(10) and § 54.1-3010 of the Code of Virginia (1950), as amended, on, October 17, 2002, at 1:00 p.m., in the offices of the Department of Health Professions, 6606 West Broad Street, Southern States Building, Fourth Floor, Richmond, Virginia. You may be represented by an attorney at the Informal Conference.

The Special Conference Committee, which is comprised of two or three members of the Virginia Board of Nursing, will inquire into allegations that you may have violated § 54.1-3007(2), (3), (5), (6) and (8) of the Code of Virginia (1950), as amended, and 18 VAC 90-20-300(A)(1) and (2)(a), (c), (e) and (f) of the Regulations of the Board of Nursing, in that:

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

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

   B. You directly involved yourself 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 your practice of relocating drugs awaiting destruction to your office until the assistant director of nursing requested that she check into this procedure. Your documentation of the destruction of drugs was disorganized at best, and you listed as witnesses to the destruction of the narcotics nurses who subsequently denied observing you 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 your practice of re-locating drugs awaiting destruction until the January 12, 1998 memo. After this memo was issued, you continued with the removal of narcotics.

Additionally, you co-signed for the destruction of narcotics with Pharmacist A, a pharmacist with whom you 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 your appearance and behavior. You were eventually confronted and agreed to take a leave of absence to receive treatment. You were placed on short-term disability leave from December 1997 to February 1998. You 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, you documented that you borrowed two (2) tablets of Percocet from Resident B for Resident Cat noon. One (1) of these tablets was later charted as administered at 5:30 p.m. by an evening nurse, Nurse D, who reported you had supplied him with only one (1) tablet for the Resident. You failed to account for the disposition of the second tablet.

E. Your employment was terminated in June 1998 due to your breach of medication-related policies.

2. During the course of your 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, you directly involved yourself 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, you instituted a new "security" procedure whereby all drugs awaiting destruction were placed in a locked box inside a padlocked filing cabinet in your nursing office. The padlock opened with a combination that you had set. Although a key was needed to gain entry to the locked box, you obtained an extra set of keys for yourself, and the key for the locked box was kept in the unlocked desk drawer in the nursing office. Your 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 your own admission, this was a system you had also previously instituted at Stratford Hall Nursing Center and at Westport Convalescent Center, both of Richmond, Virginia. By your own admission, you continued involvement in narcotics administration of narcotics even after you had stated you would stop and a new drug destruction policy was instituted in November 1998 that excluded you from any direct involvement.

B. In September 1998, you approached Nurse E on your unit, and requested the remainder of the time-release morphine sulfate left after the death of Resident F so that you could destroy the drug. When Nurse E questioned you regarding the destruction policy for these three full cards of morphine tablets, you assured her the Director of Nursing could destroy drugs by herself. You then took the drugs and the corresponding sign-outs records with you, without pharmacy participation. There is no documentation of the destruction of these morphine tablets. On or about October 5, 1998, you 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, you 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 your withdrawal on October 6, 1998, of two (2) 50mg vials of Demerol with no wastages recorded, followed by your destruction of the remaining twenty-two (22) vials of Demerol, dated by you as occurring on October 5, 1998. You 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, you took the remaining Roxicet for ostensible destruction and instructed staff to have it discontinued.

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

F. On or about October 22, 1998, you 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, you approached Nurse K and instructed her to sign out and chart your administration of morphine sulfate to Resident J. Both nurses did as you instructed and charted the withdrawal and administration of the doses, since you took the morphine sulfate from them without documenting its withdrawal or disposition. In neither case did you offer to administer the rest of the resident's medications.

G. On or about October 23, 1998, you 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, you 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, you 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, you 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, you 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, you 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, you 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. You 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, you 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. You 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, RN, LNP, denies that she or Joseph James, M.D., of Richmond, Virginia, authorized this prescription, and states that she explicitly told you 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 you, 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, your employment was suspended when you "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. Your employment was terminated on or about January 5, 1999, based on your continued administration of medications, failure to follow supervisory instructions to discontinue involvement with narcotics, failure to address various administrative and resident care issues under your purview, and continued suspicions of your diverting drugs.

3. During the course of your employment as the Director of Nursing with Fredericksburg Nursing Home, Fredericksburg, Virginia:

A. Between approximately June 2001 and October 2001, you repeatedly discontinued residents' narcotic medications when staff felt the resident still needed the narcotic, then, often on the same day, you 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
1)								
2)	R	Duragesic patch (fentanyl, Schedule II),	09/13/01	09/15/01				
3)	S	Endocet (oxycodone, Schedule II),	09/13/01	09/19/01	09/19/01	09/24/01		

3)	S	Endocet (oxycodone, Schedule II),	09/13/01	09/19/01	09/19/01	09/24/01		
4)	T	Morphine (10)	10/01/01	10/02/01				
5)	U	MS Contin (morphine sulfate, Schedule II)	06/09/01	08/19/01				
6)	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
7)	V	Hydrocodone	07/19/01	09/11/01	09/11/01	09/12/01	09/12/01	
8)	V	Hydrocodone	10/23/01	01/22/02	01/22/02			
9)	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
10)	V	Lorazepam	07/19/01	09/11/01	09/11/01			
11)	V	Methadose	07/23/01	09/11/01	09/11/01	09/12/01	09/12/01	Not d/c'd
12)	V	Methadose	01/09/02	01/11/02	01/11/02	01/22/02	01/23/02	
13)	W	Hydrocodone	09/14/01	09/21/01	09/21/01	10/15/01		
14)	W	2nd Hydrocodone	09/14/01	>>	>>	10/15/01		
15)	X	Hydrocodone	09/05/01	09/06/01	09/06/01	Not d/c'd		
16)	X	Duragesic	09/07/02	09/14/01	09/14/01	10/11/01	10/18/01	
17)	Y	Hydrocodone	08/11/01	08/14/01	08/14/01	09/25/01		
18)	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 your involvement in the HPIP, you continued to get orders discontinued and to take drugs from the units, ostensibly for destruction. Your signature appears on disposal records for the following:

	RESIDENT	DRUG	DATE DOSES DISPOSED
2)	Z	Tylenol #3	01/24/02
3)	AA	Hydrocodone	01/22/02
4)	V	Hydrocodone	01/22/02
5)	BB	Hydrocodone	01/24/02
6)	BB	Tylenol #3	01/24/02
7)	CC	Oxycontin	01/22/02

C. In approximately early January 2002, by your own admission, you were observed by Nurse DD, to pour out a measure of liquid morphine sulfate (Schedule II) into a measuring cup. Nurse DD informed you that pouring the medication out was not necessary, as the bottle was marked, then watched you pour the liquid back into the morphine sulfate bottle. However, on another, unspecified date, you were observed by Nurse EE, to pour out a measure of blue liquid morphine sulfate (Schedule II), and then walk into the medication room for a few moments. Upon your return, Nurse EE asked what you were doing and advised you that the bottle was marked for easy counting and that the liquid was not poured out to be counted. Nurse EE observed you to pour 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 you had said the morphine sulfate was not being used, so you 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, you 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.

4. You have contracted 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 HPIP. This was done with the understanding that the program is to assist those persons who have an impairment, defined as "a physical or mental disability, including, but not limited to substance abuse, that substantially alters the ability of a practitioner to practice his profession with safety to his patients and the public." Your history with the HPIP includes:

A. In February 1999, you entered into a Participation Contract.

B. Between March 11, 1999 and September 1, 1999 you completed intensive outpatient

treatment and aftercare through Williamsburg Place of Richmond, Midlothian, Virginia.

C. On or about May 17, 1999, you entered into a Recovery Monitoring Contract with the HPIP.

D. In June 1999, the HPIP Committee granted you a stay of disciplinary action.

E. On or about November 19, 1999, you relapsed on alcohol and Darvocet-N 100 (propoxyphene napsylate with acetaminophen, Schedule IV).

F. On or about January 24, 2002, you checked yourself into the Pine Grove Rehabilitation Center, in Mississippi.

G. You signed a revised Recovery Monitoring Contract on or about January 30, 2002, following your admitted ingestion of four (4) tablets of Vicodin (hydrocodone bitartrate, Schedule III) obtained from a prescription filled approximately a year previously. You had failed to advise VMI of the prescription or of your relapse and self-medication with the Vicodin.

H. Your stay of disciplinary action was vacated on February 15, 2002, based on your failure to call for or submit to urine drug screens, and your continued use of unauthorized drugs or alcohol.

Since, prior to your Informal Conference, you entered into a written agreement 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 HPIP, the Committee will take that into consideration and could, among other options, decide to continue your case with no disciplinary action, pending your compliance with your HPIP contracts.

After the conference, the conference committee is authorized to take the following actions:

1. If the committee finds that there is insufficient evidence to warrant further action or that the charges are without foundation, the committee shall notify you by mail that your record has been cleared of any charge which might affect your right to practice nursing in the Commonwealth;

2. The committee may place you on probation with such terms as it may deem appropriate;

3. The committee may reprimand you;

4. The committee may modify a previous Order;

5. The committee may impose a monetary penalty pursuant to § 54.1-2401 of the Code; or

6. The committee may refer the case to the Board of Nursing or a panel thereof for a formal hearing. If the Conference Committee is of the opinion that a suspension or revocation of your license may be justified, the committee may offer you a consent order in lieu of a formal hearing.

If you fail to appear at the informal conference, the Conference Committee will proceed to hear the case in your absence, and may take any of the actions outlined above.

At least ten (10) days prior to the scheduled date of the conference, please inform this office of your

telephone number and whether you intend to appear at the conference. This can be done by calling our offices at (804) 662-9950 or by sending us a letter at the address listed above.

You have the right to information that the Board will rely upon in making a decision. Therefore, I have enclosed a copy of the documents that will be distributed to the members of the Committee. The Committee, when discussing the allegations with you and deliberating upon your case, will consider these documents. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. Please bring these documents with you.

If you have any additional documents to be presented to the Conference Committee, please bring five (5) copies of each document with you.

Also, enclosed are copies of the relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws and regulations relating to the practice of nursing in Virginia that are cited in this notice.

Sincerely,

Jay P. Douglas, R.N., M.S.M., C.S.A.C.
Deputy Executive Director, Discipline

JPD/alt/klb
Enclosures

cc: Robert A. Nebiker, Director, Department of Health Professions
James L. Banning, Director for Administrative Proceedings
Pamela Twombly, R.N., Regional Investigative Supervisor (Case No. 53743)
Martha W. Miller, L.P.N., Senior Investigator (Case No. 8400)
Donna P. Whitney, L.P.N., C.S.A.C, Intervention Program Manager
Committee members
Ann L. Tiller, Senior Adjudication Analyst, Administrative Proceedings Division
Bob Donnelly, Esquire