COMMONWEALTH of VIRGINIA

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September 10, 2015

Amanda Moore, R.N., L.N.P.
P O Box 1043
Clintwood, Virginia 24228

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201 Hampton Street
Clintwood, Virginia 24228

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RE: VA License Nos.: 0024-170245
0017-140593
0001-196531
Expiration Date: November 30, 2016

Dear Ms. Moore:

This is official notification that an informal conference will be held pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), **on October 7, 2015 at 10:30 a.m.,** at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233. You may be represented by an attorney at the conference. This informal conference will be convened as a public meeting pursuant to § 2.2-3700 *et seq.* of the Code.

The Special Conference Committee ("Committee"), which is comprised of at least three members of the Virginia Committee of the Joint Boards of Nursing and Medicine ("Committee of the Joint Boards"), will inquire into allegations that you may have violated certain laws and regulations governing the practice of nurse practitioners in Virginia.

Specifically, during the course of your employment as a nurse practitioner with Community Medical Care, Lebanon, Virginia, you may have violated §§ 54.1-2915(A)(3), (13), (17), and (18), 54.1-3007(2), (5), and (8), 54.1-3303(A), and 54.1-3408(A) of the Code, 18 VAC 90-20-300(A)(2)(b) and (f) of the Regulations Governing the Practice of Nursing, and 18 VAC 90-30-220(4) of the Emergency Regulations Governing the Licensure of Nurse Practitioners in that:

1. In your care and treatment of Patient A, a female in her mid-40's diagnosed with generalized osteoarthritis, degenerative joint disease, migraines, insomnia due to chronic pain and anxiety with

depression (among other things), from approximately December 2012 until the patient's death in October 2014 due to acute combined oxycodone (C-II), alprazolam (C-IV), and cyclobenzaprine intoxication:

a. Beginning on or about December 5, 2012, when you took over the patient's care from another provider in the practice, you prescribed controlled substances for the treatment of her pain, anxiety with depression, and insomnia, including narcotics, benzodiazepines, sedative-hypnotics, and muscle relaxants, without attempting to treat the patient with non-narcotic modalities and despite the following indicia of drug seeking and substance misuse or abuse being noted in her record:

i. On or about July 16, 2012, it was noted that the patient called the practice stating that "she went to the eye doc [sic] today that he stated that the reason she was seeing black dots is because her stress is too high. Patient needs you to increase her dose of Klonopin, put her on Lortab, and send her in a sleeping pill …"

ii. On or about March 11, 2013, when the patient visited Wellmont Medical Center, Norton, Virginia, complaining of ankle pain, the physician who examined her noted that the patient required surgery but that "at this time she is taking heavy doses of narcotics. This will be a problem. She cannot even stand up without holding onto the wall. She cannot even open her eyes … I think it is going to be a problem to take care of her."

iii. On or about June 20, 2013, Patient A's urine toxicology screen was negative for her prescribed Xanax (alprazolam, C-IV), yet you continued to prescribe Xanax to her.

iv. On or about August 17, 2014, Patient A's urine toxicology screen was negative for her prescribed oxycodone, yet you continued to prescribe oxycodone to her.

b. Despite the fact that Patient A's condition did not improve under your care, you continued to prescribe narcotics, benzodiazepines, sedative-hypnotics, muscle relaxants, ropinirol, and neurontin without any further referrals to specialists after March 2013 or any indication that you consulted with Patient A regarding the possibility that continued use of narcotics could make her pain worse.

c. Despite requiring Patient A to sign a controlled medications policy in May 2013, there is no indication in the record that you conducted pill counts at each visit, required Patient A to submit to random urine toxicology screens, or reviewed the patient's Prescription Monitoring Report to determine whether she was taking her medications as prescribed by you or whether she was being prescribed controlled medications by other providers.

2. In your care and treatment of Patient B, a male in his mid-50's diagnosed with degenerative joint disease, osteoarthritis, degenerative spondylolisthesis, anxiety, and insomnia (among other things), from approximately July 2012 until the patient's death in September 2014:

a. Beginning on or about November 7, 2012, when you took over the patient's care from another provider in the practice, you continued to prescribe controlled substances for the treatment of his pain, anxiety, and insomnia, including hydrocodone, oxycodone, sedative-hypnotics, and muscle relaxants, without attempting to treat the patient with non-narcotic modalities and despite the following indicia of substance misuse or abuse being noted in his record:

i. August 7, 2009: "patient has failed UTOX in the past, not comfortable writing controlled meds."

ii. December 9, 2009: "patient did not keep appointment with referrals to pain clinic."

iii. June 8, 2011: "call from … Total Home Care states that she went to admit patient to home health and patient became irate and refused. She discharged him but she received a phone call from patient's insurance stating that they requested patient meds be monitored because they have concerns about his narcotics. Also wanted us to know the patient is traveling to Washington DC to get methadone."

iv. July 10, 2012: "patient missed his appointment with pain management with Dr. Gutti. Also patient is [sic] not been here for > 6 months … patient has missed several appointments with neurosurgery, pain management … referral initiated to a chronic pain specialist … due to previous hx of non compliance, also please refer to previous UTOX report, will hold off on controlled meds for now, patient also has been on methadone, will refer him to pain management …" It was further noted that the provider recommended that Patient B decrease his consumption of alcohol.

v. July 12, 2012: "patient is refusing to go to appointment with Dr. Gutti states he has been there before and they can not do anything for him."

vi. July 27, 2012: "Southeastern Pain management refusing to see patient because of noncompliance."

vii. December 10, 2012: A note from Pain Medicine Associates, Kingsport, Tennessee, stated "he was previously seen at a pain clinic in Washington, D.C. … evidently on methadone 10mg as well as oxycodone … he is no longer being seen at the clinic … he says he called there for an appointment and they told him they were not available … will need to obtain records from previous pain clinics for review prior to deciding whether to accept the patient for care here."

viii. On or about January 10, 2013, you noted "UTOX today – keep follow up with pain management. Instructed I would no longer write his pain medication after this month."

ix. On or about January 10, 2013, Patient B's urine toxicology screen was positive for oxymorphone (C-II), which you did not prescribe.

x. On or about April 26, 2013, after having surgery at Highlands Neurosurgery, Bristol, Tennessee, Patient B was prescribed MS Contin (morphine, C-II) 30mg, 1 tab bid #60 (a 30-day supply) and oxycodone 10mg 1 q 6 hours #90 (a 22.5-day supply), yet you prescribed oxycodone 20mg #120 nine days later, on May 7, 2013.

xi. On or about August 30, 2013, Patient B's urine toxicology screen was positive for morphine and oxymorphone, which you did not prescribe. You noted "morphine 15mg from pain clinic

Southeast Pain Clinic;" however, there is no record in Patient B's chart that Southeast Pain Clinic was treating Patient B, and Southeast Pain Clinic had refused to treat Patient B in July 2012.

b. From August 2013 until September 2014, despite the fact that Patient B's condition did not improve under your care, you continued to prescribe oxycodone, Flexeril (cyclobenzaprine, C-IV), Klonopin (clonazepam, C-IV), Ambien, and Neurontin (gabapentin), and to inject Patient B with Toradol (ketorolac), without any further referrals to specialists or any indication that you consulted with Patient B regarding the possibility that continued use of narcotics could make his pain worse. Further, on April 30, 2014, you increased Patient B's dosage of oxycodone from 20mg every 6 hours to 30mg every 4-6 hours without explanation.

c. Despite requiring Patient B to sign a controlled medications policy in December 2012 and August 2013, there is no indication in the record that you conducted pill counts at each visit, required Patient B to submit to more than one random urine toxicology screen, or reviewed the patient's Prescription Monitoring Report to determine whether he was taking his medications as prescribed by you or whether he was being prescribed controlled medications by other providers.

3. In your care and treatment of Patient C, a male in his early 70's diagnosed with COPD, degenerative joint disease with chronic low back pain, osteoarthritis, and anxiety (among other things), from approximately October 2012 until the patient's death in August 2014:

a. Beginning on or about February 6, 2013, you prescribed Patient C narcotic medications, including Lortab and fentanyl, even though you knew or should have known that Patient C had entered into a controlled medication contract with Dr. Gutti of the Pain Management Center in June 2012 and you noted on December 6, 2012 that the patient was receiving OxyContin and Percocet from "pain management."

b. Between March 13, 2014 and July 9, 2014, you increased Patient C's transdermal fentanyl (C-II) dose despite the following:

i. On or about April 10, 2014, you increased his dosage from 25mcg to 50mcg every 72 hours without documenting an adequate rationale.

ii. On or about July 9, 2014, you increased his dosage from 50mcg to 75mcg every 72 hours despite his telling you that narcotics helped with his pain level and he was "stable on fentanyl and norco."

c. You continued to prescribe potentially dangerous drugs or combinations of drugs to Patient C despite the following:

i. Although a drug utilization note dated November 12, 2012, indicated that using SSRI's and tramadol together may lead to an increased risk of seizures and serotonin syndrome, which is marked by hypertension, hyperthermia, and mental status changes, as well as a decrease in analgesic efficacy, you prescribed fluoxetine and tramadol to Patient C (or noted that he was currently taking these medications) at 14 monthly follow-up visits thereafter.

ii. Although a drug utilization note dated June 4, 2012, indicated that the the concomitant use of benzodiazepines and muscle relaxants increased the risk of seizure and/or serotonin syndrome, you prescribed benzodiazepines and muscle relaxants to Patient C (or noted that he was currently taking these medications) at 16 monthly visits beginning in October 2012.

iii. Although drug utilization notes dated January 16, 2012 and January 15, 2013, indicated that the use of muscle relaxants in elderly patients created the high risk of anticholinergic adverse effects, sedation, disorientation, and weakness, and although Patient C's previous provider indicated that he would discontinue muscle relaxants on January 16, 2012, you prescribed muscle relaxants to Patient C (or noted that he was receiving muscle relaxants) in 18 monthly visits beginning in October 2012.

iv. On or about November 21, 2013, a note in Patient C's record indicated that the patient's wife had called stating that the patient was refusing to take his medications and exhibiting unusual, violent behavior, potential side effects of the medications you were prescribing him.

d. You failed to adequately monitor Patient C for compliance with his treatment plan, in that you failed to document performing pill counts randomly or at each visit or accessing his Prescription Monitoring Program report, and you required only one urine drug screen, which was taken in the month of his death.

4. In your care and treatment of Patient D, a female in her mid-50's being treated for chronic low back pain and depressive disorder (among other things) from approximately November 2012:

a. You failed to adequately monitor Patient D for compliance with her Controlled Medications Contract, in that you failed to document performing pill counts randomly or at each visit or accessing her Prescription Monitoring Program report. Further, when Patient D tested negative for her prescribed Ultram (tramadol) on or about November 19, 2013, you failed to review this result with her and continued to prescribe Ultram to her.

b. You continued to prescribe narcotics, including Percocet and tramadol, to Patient D for treatment of her low back pain, despite the following:

i. On or about June 3, 2013, you sent a letter of referral to Center East Tennessee Brain & Spine, and on or about July 16, 2013, you noted "refer to neurosurgery" for Patient D's low back pain. However, there is no indication that Patient D was examined with regard to her pain until she was seen at Pikeville Medical Center on or about October 27, 2014.

ii. On or about October 2, 2014, you prescribed Percocet to Patient D even though you noted, "she has been to neurosurgery" and "patient agrees to go to pain management" but that her "pain is uncontrolled with Percocet and Ultram. Percocet and Ultram causes decreased analgesia per genetic testing performed in July. Patient agrees to go to pain management and states her arthritis pain is worse too.... She would be unable to work without her Percocet even though it is not helping with her pain very much."

iii. On or about November 3, 2014, you prescribed Percocet to Patient D even though you noted, "refer to pain management due to pharmacogenetics testing stating patient will have reduce [sic] analgesic to Percocet."

Please see Attachment I for the names of the patients referred to above.

In its deliberations, the Committee may use the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at http://www.dhp.virginia.gov/nursing. Please click on *Guidance Documents*, then select #90-7. You may also request a paper copy from the Board office by calling (804) 367-4515.

After the informal conference, the Committee is authorized by § 54.1-2400(10) of the Code to take any of the following actions:

- 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 as a nurse practitioner in the Commonwealth;
- The Committee may place you on probation for such time as it may designate and subject to such terms and conditions as it may deem appropriate;
- The Committee may reprimand you;
- The Committee may modify a previous order; or
- The Committee may impose a monetary penalty.

Further, the Committee may refer the case to the Board of Nursing or a panel thereof for a formal hearing. If the Committee is of the opinion that suspension or revocation may be justified, the Committee may offer you a Consent Order for suspension or revocation in lieu of a formal hearing.

If you fail to appear at the informal conference, the Committee may proceed to hear the case in your absence and may take any of the actions outlined above. At least ten days prior to the scheduled date of the conference, please inform this office at (804) 367-4576, or in writing at the address listed above, of your telephone number and whether you intend to appear at the informal conference.

To facilitate this proceeding, you should submit five copies of any documents you wish the Committee to consider to the Department of Health Professions, Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, by **September 24, 2015**. Your documents may not be submitted by facsimile or email.

You have the right to the information on which the Board will rely in making its decision. Therefore, I have enclosed a copy of the documents that will be distributed to the members of the Committee and will be considered by the Committee when discussing any allegations with you and when deliberating on your case. **These documents are enclosed only with the original notice sent by certified mail, which you may be required to claim at the post office. Please bring these documents with you to the informal conference.**

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of nursing and other healing arts in Virginia cited in this notice, can be found on the Internet at http://leg1.state.va.us. To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

Sincerely,

for Gloria D. Mitchell-Lively, R.N., M.S.N., M.B.A.
Deputy Executive Director

GML/dg

Enclosures

cc: Anne G. Joseph, Deputy Director, Administrative Proceedings Division
Special Conference Committee Members
Robin Carroll, Senior Investigator (Case #159867)
William Moffett, Esquire, 208 East Main Street, Abingdon VA 24212