COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Nursing

Nancy K. Durrett, R.N., M.S.N.
Executive Director
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June 24, 2002

Kelly A. Peren, R.N.,
10411 Armstrong Street
Fairfax, Virginia 22030

CERTIFIED MAIL
7160 3901 9844 7518 3127

RE: Notice of Formal Hearing
July 17, 2002, at 1:00 p.m.

Dear Ms. Peren:

Enclosed please find a Notice of Hearing, which is scheduled for July 17, 2002, at 1:00 p.m., at the Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia. Arrangements should be made for you to be there a half hour early.

You have the right to have a copy of the investigative report and supporting documents that may be used as evidence at your hearing. Please be advised that these documents have been forwarded to you under same cover via certified mail.

Prior to the hearing, it is the Board's intention to distribute these documents to the members of the Board who will conduct the hearing. If you have any objections to the materials, please contact Ann L. Tiller, Senior Adjudication Analyst, Administrative Proceedings Division, at (804) 662-7443 before July 2, 2002. If you do not object to this proposed distribution before July 2, 2002, the Board will assume that you have no objection to the Board member's prior review of the documents. Failure to object to the distribution prior to the hearing will not affect your right to contest any information contained in these documents at the hearing.

Please advise us whether or not you plan to be present for the hearing no later than July 2, 2002. If you should have any questions, please contact us at the above number.

Sincerely,

Nancy K. Durrett

Nancy K. Durrett, R.N., M.S.N.
Executive Director

Virginia Board of Nursing 1903 - 2003
Regulating Nursing - Protecting the Public

NKD/alt

Enclosures

cc: Members, Board of Nursing
Robert A. Nebiker, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Frank W. Pedrotty, Sr. Assistant Attorney General
Heather Johnson, Legal Assistant, Office of the Attorney General
William Addison Hurst, Pharmacist, Regional Investigative Supervisor, Division of Enforcement (83877)
Donna P. Whitney, L.P.N., C.S.A.C, Intervention Program Manager
Ann L. Tiller, Senior Adjudication Analyst, Administrative Proceedings Division

VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: KELLY A. PEREN, R.N.

NOTICE OF HEARING

Pursuant to § 2.2-4020, § 2.2-4021, § 54.1-110 and § 54.1-2400(11) of the Code of Virginia (1950), as amended, Kelly A. Peren, R.N., who previously held License No. 0001-144472 which expired May 31, 2002, is hereby given notice that, pursuant to § 2.2-4024 F, a formal administrative hearing will be held in the presence of a panel of the Board of Nursing ("the Board"). The hearing will be held on July 17, 2002, at 1:00 p.m., at the offices of the Department of Health Professions, (Southern States Building), 6606 West Broad Street, Fourth Floor, Richmond, Virginia, at which time Ms. Peren will be afforded the opportunity to be heard in person or by counsel.

At the hearing Ms. Peren has the following rights, among others: the right to representation by counsel, the right to have witnesses subpoenaed and to present witnesses on her behalf, the right to present documentary evidence and the right to cross-examine adverse witnesses. If Ms. Peren desires any witnesses to appear on her behalf, she must notify the Director of Administrative Proceedings, 6606 West Broad Street, Richmond, Virginia 23230-1717, giving the names and addresses of the witnesses, at least fifteen (15) days prior to the date of the hearing in order that subpoenas may be issued.

The purpose of the hearing is to receive and act upon evidence that Ms. Peren may have violated certain laws and regulations governing the practice of nursing in Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board alleges that Kelly A. Peren, R.N., may have violated § 54.1-3007(2), (5) and (6)

of the Code of Virginia (1950), as amended, and 18 VAC 90-20-300(A)(2)(a), (c), (e) and (f) of the Regulations of the Board of Nursing, in that:

1. During the course of her employment with Northern Virginia Community Hospital, Arlington, Virginia, in the time period of November 2001, Ms. Peren, R.N., wrongly medicated patients with doses of narcotic analgesics that were higher than ordered by the treating physician. She would also administer pain medications when she had no physician orders for the drugs administered.

   A. Ms. Peren reported to the hospital to care for patients on many shifts when she was not on the schedule, especially on weekends, to include on Sunday, November 25, 2001. By her own admission, Ms. Peren asked for the narcotics keys on that date so she could medicate "her" patients, although she had not received report from the outgoing nursing staff on the condition of the patients. In addition, staff observed Ms. Peren working on patients' charts on this date, and, by her own admission, she did take a verbal order and reduce it to writing.

   B. Ms. Peren acknowledges she has boundary violation issues in many areas of patient care, and is aware that she becomes overly emotionally involved with patients when she provides direct care. In order to avoid direct patient care, Ms. Peren accepted a supervisor position at this facility, but eventually began doing patient care.

   C. Ms. Peren feels as though she had to "properly" care for some patients even though these patients did not have physicians' orders for some of the care she provided. Ms. Peren stated that the problem was not with her giving "needed

medications" to the patients, but that the hospital had several ventilator patients who were not being treated appropriately. Ms. Peren stated that these patients had drug orders that were insufficient to meet their pain needs; however, she failed to obtain these "needed" orders from a physician. By her own admission, Ms. Peren signed out higher doses of medications than the physician orders called for, and did not always chart the higher doses administered to the patients. She acknowledged that this was true for Patients A through C on or about November 18 through 24, 2001. Ms. Peren stated that she knew what she had done in signing out medication not ordered by a physician and administering it to her patients was wrong, but stated, "the entire system is wrong."

D. As a result, Ms. Peren's employment was suspended.

2. During the November 2001 time period a review of the Controlled Drug Administration Records and Patient Medication Administration Records ("MARs") was conducted because of Ms. Peren's medication administration charting discrepancies and possible drug seeking behavior, to include her coming into work and requesting the narcotics keys when she was not scheduled to work. The review of records revealed the following:

A. Regarding Patient A:

1) On or about November 24, 2001, Ms. Peren signed out on the CDAR as removing one tablet of Demerol 75 mg (Meperidine), a Schedule II controlled substance; however, she failed to chart the administration of

the medication on the MAR.

2) On or about November 23, 2001, Ms. Peren signed out on the CDAR as removing one tablet of Demerol 75 mg; however, she failed to chart the administration of the medication on the MAR. The physician's order was for 50 mg of Demerol. Additionally, the MAR notes that the medication was discontinued from the original order to every 6 hours as needed for pain. It is unclear who made the change.

3) On or about November 20, 2001, Ms. Peren signed out on the CDAR as removing two (2) tablets of Demerol 75 mg; however, she failed to chart the administration of the medication on the MAR.

4) On or about November 19, 2001, Ms. Peren signed out on the CDAR as removing one tablet of Demerol 75 mg; however, she failed to chart the administration of the medication on the MAR.

B. Regarding Patient B:

1) On or about November 23, 2001, Ms. Peren signed out on the CDAR as removing two (2) tablets of Percocet (oxycodone), a Schedule II controlled substance; however, she failed to chart the administration of the medication on the MAR.

2) On or about November 21, 2001, Ms. Peren signed out on the CDAR as

removing two (2) tablets of Percocet; however, she failed to chart the administration of the medication on the MAR.

3) On or about November 18, 2001, Ms. Peren signed out on the CDAR as removing one tablet of Percocet; however, she failed to chart the administration of the medication on the MAR.

C. Regarding Patient C:

1) On or about November 23, 2001, Ms. Peren signed out on the CDAR as removing one tubex of Dilaudid 4 mg (hydromorphone), a Schedule II controlled substance; however, she failed to chart the administration of Dilaudid on the MAR. Further, the patient reported that Ms. Peren did not administer the medication to her.

2) On or about November 21, 2001, Ms. Peren signed out on the CDAR as removing nine (9) tubexes of Dilaudid 4 mg, one tubex of Dilaudid 2 mg, and two (2) tablets of Ativan (Lorazepam), a Schedule IV controlled substance. Ms. Peren failed to chart the administration of Dilaudid removed at 1130, 1200, 1500 and 1830, and failed to chart the administration of the Ativan on the MARs. Additionally, she documented twice on the CDAR as having removed Dilaudid at 1400, and failed to chart one (1) of the two (2) doses on the MAR.

3) On or about November 20, 2001, Ms. Peren signed out on the CDAR as

removing six (6) tubexes of Dilaudid 4 mg and two (2) tubexes of Dilaudid 4 mg; however, she failed to chart the administration of Dilaudid removed at 1520 and 1600 on the MAR.

4) On or about November 19, 2001, Ms. Peren signed out on the CDAR as removing four (4) tubexes of Dilaudid 2 mg and two (2) tubexes of Dilaudid 4 mg. In reviewing the MAR, it is unclear what Ms. Peren documented as administered to the patient.

D. As a result of the above, Ms. Peren's employment was suspended.

3. By her own admission in a signed, handwritten statement, while employed in a hospital in Arizona, Ms. Peren routinely worked outside of the scope of her practice, to include administering Diprivan (propofol, Schedule VI) in the absence of physicians' orders, at doses which Ms. Peren characterized as "anesthesia at those levels."

FOR THE BOARD

Nancy K. Durrett

Nancy K. Durrett, R.N., M.S.N.
Executive Director for the
Board of Nursing

ENTERED: June 24, 2002