COMMONWEALTH of VIRGINIA

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NOTICE OF INFORMAL CONFERENCE
BEFORE AN AGENCY SUBORDINATE

June 4, 2008

William Dean, R.N.
68 Major Street
Lebanon, Virginia 24266

CERTIFIED MAIL
71603901984518473499

and

5302 Woodland Terrace
Tuscaloosa, Alabama 35405

CERTIFIED MAIL
71603901984518473505

Re: VA License No.: 0001-160434
Expiration Date: July 31, 2009

Dear Mr. Dean:

This is official notification that an informal conference of the Virginia Board of Nursing ("Board") will be held on **July 1, 2008, at 9:00 a.m.,** at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Richmond, Virginia 23233. In accordance with §§ 2.2-4019, 2.2-4021, and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), this informal conference will be held before an agency subordinate of the Board of Nursing. This informal conference will be convened as a public meeting pursuant to § 2.2-3700 *et seq.* of the Code. The agency subordinate will inquire into allegations that you may have violated certain laws and regulations governing professional nursing practice in Virginia. Specifically,

1. You may have violated § 54.1-3007(2), (5) and (8) of the Code and 18 VAC 90-20-300(A)(2)(c) of the Board of Nursing Regulations in that, during the course of your employment with Carilion Roanoke Memorial Rehabilitation Center, Roanoke, Virginia, a review of medications withdrawn from the Pyxis by you from March 1, 2007 through April 2, 2007, disclosed the following discrepancies:

a. On or about March 2, 2007, at 7:27 p.m., you withdrew one Fentanyl 25mcg/HR patch (Schedule II) for Patient A. However, you failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the medication administration record ("MAR") or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 3, not March 2.

b. On or about March 3, 2007, at 9:27 p.m., you withdrew one Fentanyl 100mcg/HR patch for Patient B. However, you failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the MAR or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 5, not March 3.

c. On or about March 5, 2007, at 6:13 a.m., you withdrew one Oxycodone 5mg tablet (Schedule II) for Patient B; however, you charted administering 10 mg of Oxycodone.

d. On or about March 5, 2007, at 6:28 a.m., you withdrew two Hydrocodone/APPA 7.5/500mg tablets (Schedule III) for Patient C. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document whether the medication was returned or wasted.

e. On or about March 9, 2007, at 9:33 p.m., you withdrew one Lorazepam 1mg tablet (Schedule IV) for Patient D and documented administering 0.5mg. However, you failed to document wasting the remaining 0.5mg.

f. On or about March 10, 2007, at 2:57 a.m., you withdrew one Fentanyl 100mcg/HR patch for Patient D. However, you failed to chart the removal of the existing patch; failed to chart the withdrawn patch as administered on either the MAR or the nursing notes; and failed to document whether the patch was returned or wasted. Further, the physician's order was for this patch to be changed on March 12, not March 10.

g. On or about March 10, 2007, at 7:31 p.m., you withdrew one Oxycodone CR 20mg tablet (Schedule II) for Patient E. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately 46 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours.

h. On or about March 11, 2007, at 7: 52 p.m., you withdrew one Oxycodone CR 20mg tablet Patient E. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately 12 minutes after another nurse had withdrawn and documented as administered the same medication for this patient. The physician's order was to administer the medication every 12 hours.

i. On or about March 11, 2007, at 7:56p.m., you withdrew one Morphine 20mg/1ml (Schedule II) for Patient D and documented administering Morphine 10mg; however, you failed to document wasting the remaining 10mg.

j. On or about March 11, 2007 at 11:39p.m., you withdrew one Morphine 20mg/1ml for Patient D and documented administering Morphine 10mg; however, you failed to document wasting the remaining 10mg.

k. On or about March 12, 2007, at 6:00 a.m., you withdrew one Oxycodone CR 20mg tablet for Patient F. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately one minute after another nurse had withdrawn and documented as administered this same medication for this patient.

l. On or about March 12, 2007, at 6:29 a.m., you withdrew one Oxycodone CR 20mg tablet for Patient E. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately 18 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours as needed.

m. On or about March 16, 2007, at 7:47 p.m., you withdrew one Oxycodone CR 20mg tablet for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately 54 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours as needed.

n. On or about March 16, 2007, at 10:09 p.m., you withdrew one Oxycodone CR 5mg tablet for Patient F. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately one hour 13 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every four hours as needed.

o. On or about March 16, 2007, at 11:34 p.m., you withdrew two Hydrocodone/APAP 7.5/500 tablets for Patient C. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

p. On or about March 16, 2007, at 11:34 p.m., you withdrew two Zolpidem Tartrate 5mg tablets for Patient C. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

q. On or about March 16, 2007, at 11:52 p.m., you withdrew two Oxycodone 5mg tablets for Patient B. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

r. On or about March 17, 2007, at 3:58 a.m., you withdrew one Oxycodone 5mg tablet for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

s. On or about March 17, 2007, at 7:33 p.m., you withdrew one Fentanyl 100mcg/HR patch for Patient B. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately one hour 49 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 72 hours.

t. On or about March 17, 2007, at 9:31 p.m., you withdrew one Lorazepam 1mg tablet for Patient D and documented administering 0.5mg. However, you failed to document that the remaining 0.5mg was wasted.

u. On or about March 17, 2007, at 9:32 p.m., you withdrew one Morphine 20mg/1ml for Patient D and documented administering 10mg. However, you failed to document wasting the remaining 10mg.

v. On or about March 18, 2007, at 4:05 a.m., you withdrew two Oxycodone 5mg tablets for Patient B. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

w. On or about March 18, 2007, at 4:50 a.m., you withdrew one Oxycodone 5mg tablets for Patient B. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was wasted. The physician's order was to administer this medication every four hours as needed.

x. On or about March 19, 2007, at 12:00 a.m., you withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one Oxycodone 5mg tablet. However, you failed to document that the remaining 5mg tablet was returned or wasted.

y. On or about March 23, 2007, at 7:54 p.m., you withdrew one Oxycodone 5mg tablet for Patient F and documented the administration of the medication. At 8:12 p.m., you withdrew one Oxycodone 5mg tablet for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

z. On or about March 23, 2007, at 11:24 p.m., you withdrew one Oxycodone 5mg tablet for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document the medication was returned or wasted.

aa. On or about March 23, 2007, at 11:54 p.m., you withdrew one Oxycodone 5mg tablet for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

bb. On or about March 23, 2007, at 11:54 p.m., you withdrew one Zolpidem Tartrate 5mg tablet for Patient C. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

cc. On or about March 24, 2007, at 6:03 a.m., you withdrew two Hydrocodone/APAP 7.5/500mg tablets for Patient C. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

dd. On or about March 24, 2007, at 6:03 a.m., you withdrew two Oxycodone 5mg tablets for Patient G. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

ee. On or about March 24, 2007, at 7:26 p.m., you withdrew two Oxycodone 5mg tablets for Patient G. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

ff. On or about March 24, 2007, at 8:18 p.m., you withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one 5mg tablet; however, you failed to document that the remaining 5mg tablet was returned or wasted.

gg. On or about March 25, 2007, at 4:42 a.m., you withdrew two Oxycodone 5mg tablets for Patient F, and documented administering one 5mg tablet; however, you failed to document that the remaining 5mg tablet was returned or wasted.

hh. On or about March 25, 2007, at 11:46 p.m., on two separate occasions at 11:46 p.m., you withdrew one Oxycodone 5mg tablet each time for Patient H. You documented administering one of the tablets; however, you failed to document that the remaining 5mg tablet was returned or wasted.

ii. On or about March 26, 2007, at 12:14 a.m., you withdrew one Hydrocodone/APAP tablet for Patient I. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

jj. On or about March 26, 2007, at 3:18 a.m., you withdrew two Oxycodone 5mg tablets and documented the administration of the medication to Patient G. At 4:08 a.m., you withdrew two Oxycodone 5mg tablets for Patient G. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. The physician's order was to administer the medication every four hours as needed.

kk. On or about March 26, 2007, at 11:43 p.m., you withdrew two Oxycodone 5mg tablets for Patient F. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. The physician's order was to administer one tablet every four hours as needed.

ll. On or about March 27, 2007, at 12:38 a.m., you withdrew three Methadone 5mg tablets (Schedule II) for Patient G. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

mm. On or about March 28, 2007, at 11:26 p.m., you withdrew one Oxycodone 5mg tablet for Patient J. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

nn. On or about March 28, 2007, at 11:26 p.m., you withdrew one Oxycodone 5mg tablet for Patient K. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

oo. On or about March 29, 2007, at 12:46 a.m., you withdrew two Oxycodone 5mg tablets for Patient L. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

pp. On or about March 29, 2007, at 3:27 a.m., you withdrew one Oxycodone 5mg tablet for Patient J. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

qq. On or about March 29, 2007, at 5:56 a.m., you withdrew two Oxycodone 5mg tablets for Patient H. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately six minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication three times a day.

rr. On or about March 30, 2007, at 9:20 p.m., you withdrew one Oxycodone CR 20mg tablet for Patient M. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately three hours 40 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication every 12 hours.

ss. On or about April 1, 2007, at 12:08 a.m., you withdrew two Oxycodone 5mg tablets for Patient H. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. Further, you signed out this medication approximately one hour 11 minutes after another nurse had withdrawn and documented as administered this same medication for this patient. The physician's order was to administer the medication three times a day.

tt. On or about April 1, 2007, at 3:03 a.m., you withdrew two Oxycodone 5mg tablets for Patient G. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

uu. On or about April 1, 2007, at 7:31 p.m., you withdrew one Oxycodone 5mg tablet for Patient K. However you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

vv. On or about April 1, 2007, at 10:09 p.m., you withdrew two Oxycodone 5mg tablets for Patient L. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

ww. On or about April 2, 2007, at 12:11 a.m., you withdrew one Zolpidem Tartrate 5mg tablet for Patient L. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted.

xx. On or about April 2, 2007, at 5:52 a.m., you withdrew one Oxycodone CR 20mg tablet for Patient M and documented the administration of the medication. At 5:55 a.m., you withdrew one Oxycodone CR 20mg tablets for Patient M. However, you failed to document the administration of this medication on the MAR or in the nursing notes; nor did you document that the medication was returned or wasted. The physician's order was to administer the medication every 12 hours as needed.

yy. On or about April 2, 2007, at 6:12 a.m., you withdrew one Oxycodone 5mg tablet for Patient L; however, you charted administering 10mg of Oxycodone.

2. You may have violated § 54.1-3007(7) of the Code in that, on or about July 8, 2002, the Rhode Island Board of Nursing denied your application for licensure due to drug diversion.

3. You may have violated § 54.1-3007(2) and (5) of the Code and 18 VAC 90-20-300(A)(2)(e) of the Board of Nursing Regulations in that, on or about November 23, 2004, you submitted an Application for Employment with Carilion wherein you responded "No" to the question "Have you received disciplinary action, been placed on probation, or been investigated by any state licensing board(s)?" when, in fact, you were denied licensure in Rhode Island.

In its deliberations, the agency subordinate 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 consideration of all information, the agency subordinate may:

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

- Recommend findings of fact, conclusions of law and a sanction, to include a reprimand, placing you on probation with terms, suspension or revocation of your license, or imposing a monetary penalty pursuant to § 54.1-2401 of the Code.

Further, the agency subordinate may refer this matter for a formal administrative proceeding pursuant to § 2.2-4020 of the Code.

Board's Review of Agency Subordinate's Recommended Decision

If you **appear in person or by counsel at the informal conference**, the recommendation of the agency subordinate will be presented to a quorum of the Board. The Board may accept or modify the recommendation, or reject the recommendation and move the case to formal hearing. If you do not agree with the decision of the Board, you have the right to a formal administrative hearing before the Board.

If you **fail to appear in person or by counsel at the informal conference**, the recommendation of the agency subordinate will be presented to a quorum of the Board. The Board may accept or modify the recommendation, or reject the recommendation. The Board's decision regarding the agency subordinate's recommendation is a final order that can only be appealed to circuit court as provided by Rule 2A:2 of the Supreme Court of Virginia.

You have the right to information that will be relied upon by the agency subordinate in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the agency subordinate, and will be considered when discussing the allegations with you and when deliberating upon 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.**

To facilitate this proceeding, you should submit five copies of any documents you wish the agency subordinate to consider to the Board of Nursing, Perimeter Center, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, by June 23, 2008. Your documents may not be submitted by facsimile or email.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, because absent good cause to support a request for a continuance, the informal conference will be held on July 1, 2008. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by 12 noon on June 23, 2008. Only one such motion will be considered. Absent critical circumstances, such as personal or family illness, a request for a continuance after June 23, 2008, will not be considered

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.

Please advise the Board, in writing, of your intention to be present. If you have any questions regarding this notice, please contact Anne Joseph, Deputy Director, APD, at (804) 367-4494.

Sincerely,

Gloria Mitchell

Gloria D. Mitchell, R.N., M.S.N., M.B.A.
Deputy Executive Director, Discipline

Enclosures

cc: Sandra Whitley Ryals, Director, Department of Health Professions
Anne G. Joseph, Deputy Director, Administrative Proceedings Division
Janet Younger, R.N., P.N.P., Ph.D., Agency Subordinate
Mary Beth Shelton, Adjudication Specialist
James Wall, Senior Investigator (Case no. 114822)