COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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Virginia Board of Nursing
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September 15, 2015

Callie Robbins, R.N.
12121 Pervical Street
Chester, Virginia 23831

CERTIFIED MAIL
9414 7266 9904 2028 4915 68

Re: Virginia License No.: 0001-201115
Expiration Date: June 30, 2016

Dear Ms. Robbins:

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 14, 2015 at 1:00 p.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 two members of the Virginia Board of Nursing ("Board"), will inquire into allegations that you may have violated certain laws and regulations governing nursing practice in Virginia.

Specifically:

1. You may have violated §54.1-3007(6) of the Code in that you may be unsafe to practice nursing due to substance abuse, as evidenced by the following:

a. Between or about July 2014 and October 2014, you asked three of your co-workers for their left-over pain medications, including Percocet (oxycodone-acetaminophen, C-II), that they had received from previous treatment. By your own admission, you received the requested pain medications from two of your co-workers.

b. Between or about February 2013 and January 2015, you received 69 prescriptions for controlled substances, including medications for sleep, pain, and concentration, from a total of 11 physicians, and had the prescriptions filled at 11 different pharmacies.

2. During the course of your employment with Bon Secours St. Francis Medical Center, Midlothian

Virginia, you may have violated§54.1-3007(2), (5), (6) and (8) of the Code and 18 VAC 90-20-300(A)(2)(a), (c), (e) and (f) of the Regulations Governing the Practice of Nursing ("Regulations") in that you diverted Percocet for your own personal and/or unauthorized use, falsely documented medication administration and administered medications against physicians' orders, as evidenced by the following:

a. On or about October 28, 2014, you documented that you administered one tablet of Percocet to Patient A four times between 7:34 p.m. and 11:47 p.m. Percocet was ordered to be given one tablet every four hours as needed.

b. On or about October 27, 2014, you pulled two tablets of Percocet for Patient B; however, you failed to document the administration and/or wastage of the medication.

c. Between or about November 16, 2014 and November 17, 2014, you pulled eight tablets of Percocet for Patient C. You documented wasting an unknown number of tablets and administering five tablets. In addition, on November 16, 2014 at 6:57 p.m. you documented administering two tablets of Percocet to Patient C but the medication was ordered to be given one tablet every four hours as needed.

d. Between or about November 17, 2014 and November 19, 2014, you pulled 16 tablets of Percocet for Patient D but you only documented administration of 12 of those tablets, leaving 4 tablets unaccounted for. In addition, Percocet was ordered to be administered one tablet every four hours as needed. However, at each administration you documented administering two tablets of Percocet to Patient D.

e. Between or about November 17, 2014 and November 20, 2014, you pulled 17 tablets of Percocet for Patient E, but you only documented administering 11 tablets to the patient. In addition, you pulled two tablets of Percocet for Patient E at 9:51 p.m., but you had administered two tablets to the patient at 8:00 p.m. The medication was ordered to be given two tablets every six hours as needed. You then documented an unknown number of tablets as wasted at 11:18 p.m. but pulled another tablet approximately 30 seconds later.

f. Between or about November 16, 2014 and November 18, 2014, you pulled 22 tablets of Percocet for Patient F; however, you only documented administration of 14 tablets to the patient. You also documented a medication waste on two occasions but did not indicate the quantity of the wastage.

g. Between or about November 24, 2014 and November 26, 2014, you administered a total of 15 tablets of Percocet to Patient G; however, 14 of those tablets were administered against physician's orders. Percocet was to be administered one tablet every four hours as needed for pain. On each occasion you administered two tablets to the patient.

h. Between or about November 30, 2014 and December 1, 2014, you pulled 18 tablets of Percocet for Patient H; however, you only documented administration of 12 tablets to the patient. In addition, all 12 of the administered tablets were administered against physician's orders. Percocet was to be given one tablet every four hours as needed; on each occasion, you administered two tablets.

i. On or about December 15, 2014 and December 17, 2014, you pulled 15 tablets of Percocet for Patient I, however, you only documented administration of 10 tablets to the patient. Both the patient and her husband reported that she did not receive any Percocet during her entire stay. Additionally,

you documented administering two tablets to the patient at least five times on December 16, 2014 and December 17, 2014. Percocet was to be given one tablet every four hours as needed, with the additional instruction to repeat dose up to one hour after the current dose, if no relief.

j. On or about December 16, 2014 and December 17, 2014, you falsely documented that you administered two tablets of Percocet to Patient J on three occasions during the evening and night hours. However, Patient J reported that she had only received one tablet of Percocet through the night and that her pain had not been well controlled.

k. On or about December 16, 2014 and December 17, 2014, you falsely documented that you administered two tablets of Percocet to Patient K on three occasions, at approximately 8:13 p.m., 11:14 p.m. and 2:58 a.m. However, the patient reported that she only received pain medication early in the evening on December 16, 2014.

l. On or about November 25, 2014, you falsely documented that you administered two tabs of Percocet to Patient L at 3:13 a.m., but you did not pull the medication until 3:16 a.m. In addition, you administered Percocet to Patient L against physician's orders; Percocet was ordered to be given one tablet every four hours as needed, but you administered two tablets.

m. You frequently pulled Percocet tablets hours before they were due to be administered, you withdrew Percocet but failed to document any action regarding the medication, and, by your own admission, you withdrew Percocet tablets and carried the tablets around with you in your pockets.

Please see Attachment I for the name 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.

Since the allegations listed above involve impairment, please be advised that you may make application to the Health Practitioners' Monitoring Program ("HPMP"), which is available to all health care practitioners licensed in Virginia. Information about the HPMP is enclosed. Should you enter into a written agreement with the HPMP prior to your informal conference, the Committee will take that into consideration when deciding your case.

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 nursing 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 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) 367-4502, 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 October 5, 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,

Gloria Mitchell-Lively

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

GML/sts

Enclosures

cc: Anne G. Joseph, Deputy Director, Administrative Proceedings Division
Special Conference Committee Members
Wendy Deaner, Adjudication Specialist
Christina Bargdill, Regional Enforcement Manager (Case No. 161222)
Peggy Wood, Monitoring Program Coordinator