COMMONWEALTH of VIRGINIA

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Director

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September 10, 2015

Shelley Hicks, R.N., L.N.P.
P O Box 9
Kingsport, Tennessee 37662

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142 Hicks Lane
Castlewood, Virginia 24224

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RE:	**Virginia L.N.P. License No.:**	**0024-168229**
	Virginia Authority to Prescribe No.:	**0017-139396**
	Virginia R.N. License No.:	**0001-154100**
	Expiration Date:	**January 31, 2017**

Dear Ms. Hicks:

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") comprised of 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 nurse practitioner practice in Virginia.

Specifically, during the course of your employment with Family Health Care Associates, Lebanon, Virginia:

1. You may have violated §§54.1-3007 (5) and 54.1-2915(3), (12), (13), (17) and (18) of the Code and 18 VAC 90-30-220(4) and (6) of the Emergency Regulations Governing the Licensure of Nurse Practitioners ("Regulations") in that between or about November 19, 2013 and December 31, 2013, you failed to properly prescribe and monitor Patient A's narcotic pain medications and possible substance abuse and/or mental illness, as evidenced by the following:

a. You prescribed narcotic medications to Patient A despite the following evidence of possible abuse or misuse from prior treatment providers:

i. Medical records from Southeastern Pain Management, Bristol, Tennessee, which were in Patient A's chart, revealed a history of non-compliance with prescribed medications. On or about April 18, 2013, Patient A indicated that she had taken two tablets of hydrocodone-acetaminophen (C-II) and that the medication did not provide any relief; however, the medication was ordered to be given one tablet every eight hours as needed for pain. Furthermore, between or about May 16, 2013 and August 8, 2013, at four office visits, it was noted that Patient A admitted that she had been non-compliant with her course of treatment and that she was self-medicating.

ii. Medical records from C-Health of St. Paul, St. Paul, Virginia, which were in Patient A's chart, revealed that the patient displayed drug seeking behaviors. On or about January 29, 2013, Patient A requested a prescription for Lortab (hydrocodone, C-II), even though she was scheduled to see Dr. Roatsey, at another practice, the following week for a prescription for pain medications. The physician also noted that he suspected some of the patient's problems may be related to her alcohol use. The patient admitted that she continued to occasionally drink an alcoholic beverage. Moreover, on or about April 3, 2013, Patient A requested changes to her pain medication even though she was receiving treatment at Southeastern Pain Management.

b. Prior to prescribing narcotic mediations to Patient A:

i. You failed to complete a detailed patient evaluation. In addition, you failed to have the patient undergo any type of risk evaluation for depression or other mental health disorder. The patient's prior medical records indicated that she was previously diagnosed with depression and anxiety and you documented that the patient had an anxiety disorder, for which you prescribed the patient medication.

ii. You failed to consult with an addiction specialist despite knowing that she had a history of substance abuse as documented in her medical records. You also failed to consult with any of the patient's prior physicians.

iii. You failed to notice and/or question the fact that Patient A's medical records showed evidence of "doctor shopping" in that Patient A repeatedly changed physicians after receiving care for less than one year.

c. While prescribing narcotic medications to Patient A:

i. On or about November 19, 2013, Patient A signed a Consent for Opioid Therapy agreement with you as her prescriber. The agreement form that you used was from January 14, 1999, and failed to address the prescriber's policies and expectations, reasons for discontinuing or changing drug therapy, and the responsibilities of the prescriber and the patient.

ii. Between or about November 19, 2013 and December 31, 2013, you failed to have Patient A submit to random drug screens despite knowing that Patient A's prior medical records indicated a history of non-compliance and a history of self-medicating.

iii. Patient A's medical records indicated that you checked the Prescription Monitoring Program Report, but there is no evidence to support your documentation. In addition, the patient received treatment in Tennessee, but there is no documentation or other evidence that you checked the Tennessee Prescription Monitoring Program database.

iv. On or about November 19, 2013, you prescribed Patient A Dilaudid (hydromorphone, C-II) 4mg, one tablet every six hours as needed for pain, despite knowing that she was receiving oxycodone (C-II) from another provider and that she reported daily alcohol use.

v. On or about December 2, 2013, you prescribed Patient A oxycodone and Dilaudid even though the patient reported daily alcohol use.

vi. On or about December 31, 2013, you again prescribed Patient A both Dilaudid and oxycodone despite her report of daily alcohol use. You also prescribed the patient a hydrocodone cough syrup (C-III). Furthermore, the patient presented at your office with a letter from the Department of Motor Vehicles indicating that her driver's license would soon be suspended, in part due to a diagnosis of alcohol induced dementia. You failed to research the matter and instead completed new paperwork indicating that she was a "social drinker only" and that drug/alcohol treatment was "not applicable."

vii. You continued to prescribe the patient narcotic medications even though the patient had not displayed any progress with her treatment, and you failed to consult with a pain management specialist and/or to provide the patient with a referral to a pain management specialist.

viii. You failed to assess Patient A's level of pain at each visit. The only time you assessed and/or documented her pain level was at the first visit, when you documented a 9-10 on a 10 point pain scale. Thereafter, you only documented that Patient A reported that the medications were not strong enough and that there was no change in her pain.

2. You may have violated §§54.1-2915(A)(18) and 54.1-2957(B) of the Code, 18 VAC 90-30-122(A) of the Regulations and 90-40-90(A) and (C) of the Emergency Regulations for Prescriptive Authority for Nurse Practitioners in that between or about July 8, 2013 and January 1, 2014, you practiced as nurse practitioner without a collaborative practice agreement with a physician.

Please see Attachment I for the name of the patient 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 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 Committee of the Joint Boards of Nursing and Medicine 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,

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
Wendy Deaner, Adjudication Specialist
Jennifer Baker, Senior Investigator (Case No.'s 156583 & 156585)
Christopher Stevens, Esquire, 10 S. Jefferson Street, Suite 1400, Roanoke VA 24011