



# COMMONWEALTH of VIRGINIA

## Department of Health Professions Board of Nursing

Nancy K. Durrett, R.N., M.S.N.  
Executive Director  
nursebd@dhp.state.va.us

April 1, 2002

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Richmond, Virginia 23230-1717  
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Lisa M. Vines R.N.  
4333 SE Cove Lake Circle, Apt. 205  
Stuart, FL 34997

**CERTIFIED MAIL**  
**71064575129435553017**

**RE: License No. 0001-148840 (expired: 7/31/01)**

Dear Ms. Vines:

This is official notification that an Informal Conference will be held, pursuant to § 2.2-4019, § 2.2-4021, § 54.1-2400(10) and § 54.1-3010 of the Code of Virginia (1950), as amended, on **April 30, 2002, at 1:00 p.m.**, in the offices of the Department of Health Professions, 6606 West Broad Street, Southern States Building, Fourth Floor, Richmond, Virginia. You may be represented by an attorney at the Informal Conference.

The Special Conference Committee, which is comprised of two or three members of the Virginia Board of Nursing, will inquire into allegations that you 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)(c) and (e) of the Regulations of the Board of Nursing in that:

1. During the course of your employment with All About Staffing, Richmond, Virginia, you were assigned to providing nursing services at Columbia Retreat Hospital, Richmond, Virginia. While on duty:
  - a. On or about June 14, 2001:
    1. When at the nurse's station, two tablets of packaged oxycodone (Percocet), a Schedule II controlled substance, fell out of your lab coat pockets. You stated that the medication was for Patient A and, subsequently administered the medication to the patient. The medication administration record noted that the physician's order was for 1 to 2 tablets of Percocet every four (4) hours as needed. The Accudose Machine and the medication administration record ("MAR") note that you removed Percocet at 6:56 a.m. and

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2. administered the medication to the patient at 8:00 a.m.; however, the patient reported that you administered Percocet to her earlier at the beginning of your shift.
  3. You withdrew one tablet of Dilaudid 2 mg (hydromorphone), a Schedule II controlled substance, from the Accudose Machine at 7:40 a.m. for administration to Patient B, who was in another area of the hospital having his dialysis treatment until 11:30 a.m.
- b. On or about June 14, 2001, as a result of the incidents above, an audit of patient records and the Accudose Machine was conducted with the following results:
1. On each occasion that you reported for duty, before receiving morning report, you withdrew multiple medications from the Accudose Machine for administration to your patients.
  2. You administered more narcotics to patients than any of the other nurses, specifically, oxycodone and codeine and hydrocodone, both Schedule III controlled substances.
  3. On or about June 9, 2001, Patient C had a physician's order for oxycodone 5/325 to be administered 1-2 tablets every six (6) hours, as needed. At 6:53 a.m., you withdrew two tablets of oxycodone from the Accudose Machine for the patient and documented administering the medication to the patient at 6:55 a.m. Additionally, you withdrew two tablets of oxycodone at 11:27 a.m. from the Accudose Machine, and documented administering the medication to the patient at 11:30 a.m., at least two hours prior to what was ordered by the physician. On the MAR where you indicated administering insulin at 7:30, you circled and wrote dialysis. The purpose of this notation is unclear and unexplained on the MAR.
  4. On or about June 6, 2001, you documented the administration of two tablets of oxycodone to Patient D at 7:45 a.m. and 11:40 a.m. However, the times on the MAR you documented for administration are unclear in that they are marked through without a new time, marked through with a new time, or written over.
  5. On or about June 4, 2001, you documented as having administered oxycodone to Patient E. On or about June 3, 2001, at noon, the oxycodone for this patient was discontinued by the patient's physician.
  6. On or about June 1, 2001, you withdrew one tablet of oxycodone at 4:30 p.m. for administration to Patient F. You failed to document the administration of the medication. Further, you administered methadone and guaifensin during the 5:00 p.m. and the 9:00 p.m. medication passes without documenting the administration of the medications. Additionally, on this date, you withdrew methadone 10 mg for administration to Patient F at 12:02

p.m. and then documented wasting the medication at 12:03 p.m. with a witness. Subsequently, at 12:04 p.m., you withdrew another 10 mg tablet of the methadone, documenting administration of the medication at 1 p.m.

7. On or about May 31, 2001, you withdrew oxycodone from the Accudose for Patient G, however; you failed to document the administration of the medication on the MAR or make a note of the administration in the nurse's notes.
  - c. As a result of the above, your employment with the agency was terminated.
2. By your own admission, during the course of your employment with the Medical College of Virginia, Richmond, Virginia, from January of 1997 through January 1999, you received a counseling notice for a subcutaneous potassium intravenous infiltration.

Since the allegations listed above involve impairment, please be advised of the availability of making application to the Health Practitioners' Intervention Program ("Program") that is available to all health care practitioners licensed in Virginia. A brochure about the program is enclosed. Should you enter into a written agreement with the Program prior to your Informal Conference, the Committee will take that into consideration and could, among other options, decide to close your case with no disciplinary action.

Should you decide not to enter into a written agreement with the Program prior to your meeting with the Conference Committee, the Conference Committee is authorized, after meeting with you, to take one of the following actions:

1. 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;
2. The Committee may place your license on probation with such terms as it may deem appropriate;
3. The Committee may reprimand you;
4. The Committee may modify a previous Order;
5. The Committee may impose a monetary penalty pursuant to § 54.1-2401 of the Code; or
6. The Committee may refer the case to the Board of Nursing or a panel thereof for a formal hearing. If the Conference Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee may offer you a consent order in lieu of a formal hearing.

Lisa Vines, R.N.

Page 4

If you fail to appear at the Informal Conference, the Conference Committee will proceed to hear the case in your absence, and may take any of the actions outlined above.

At least ten (10) days prior to the scheduled date of the conference, please inform this office of your telephone number and whether you intend to appear at the conference. This can be done by calling our offices at (804) 662- 9909 or by sending us a letter at the address listed above.

You have the right to information that will be relied upon by the Board in making a 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 the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. Please bring these documents with you.

If you have any additional documents to be presented to the Conference Committee, please bring five (5) copies of each document with you.

Also, enclosed are copies of the relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws and regulations relating to the practice of nursing in Virginia that are cited in this notice.

Sincerely,



Jay P. Douglas, R.N., M.S.M., C.S.A.C.  
Assistant Executive Director

JPP/gem/dl

Enclosures

cc: Robert A. Nebiker, Director, Department of Health Professions  
James L. Banning, Director for Administrative Proceedings  
Pamela Twombly, Investigator (82305)  
Committee members  
Gayle E. Miller, Senior Legal Assistant  
Donna P. Whitney, LPN, CSAC, Intervention Program Committee Coordinator