



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 25, 200

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Sandra Carol Stevenson Chester, R.N.
Rt. 5 Box 571
Grundy, Virginia 24614

CERTIFIED MAIL

7160 3901 9844 7518 3165

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

Dear Ms. Chester:

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,

A handwritten signature in cursive script that reads "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
Emily Wingfield, Assistant Attorney General
Heather Johnson, Legal Assistant, Office of the Attorney General
Jennifer E. Baker, R.N., Division of Enforcement (82095, 82696 & 84047)
Donna P. Whitney, L.P.N., C.S.A.C, Intervention Program Committee Coordinator

VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE: SANDRA CAROL STEVENSON CHESTER, 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, Sandra Carol Stevenson Chester, R.N., a.k.a Sandy Duncan Chester, who holds License No. 0001-136680 currently expiring June 30, 2003, 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. Chester will be afforded the opportunity to be heard in person or by counsel.

At the hearing Ms. Chester 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. Chester 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. Chester 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 Sandra Carol Stevenson Chester, R.N., may have violated § 54.1-3007(2), (3), (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 Ms. Chester's employment with Tazewell Community Hospital, Tazewell,

SANDRA CAROL STEVENSON CHESTER, R.N.

Virginia:

- a. On or about June 18 through 19, 2001, while on duty from 7:00 p.m. to 7:00 a.m.:
 1. Patient A, who was assigned to Ms. Chester, became combative and attempted to get out of bed. Ms. Chester was on break, and when paged to return to the Intensive Care Unit immediately, did not respond to the page and return to the unit.
 2. By her own admission, Ms. Chester self-injected Lidocaine NS (Schedule VI), into her toe in the absence of a physician's order.
 3. Ms. Chester documented that she administered Morphine 4 mg (Schedule II), to Patient B at 0200 hours and 0615 hours. She documented the administration of both doses of the Morphine on the Medication Administration Record ("MAR"); however, she failed to document completely the 0615 dose on the MAR, and did not document administration of the medication in the nurse's notes.
 4. At 0600 hours, Ms. Chester signed out Morphine 2 mg for administration to Patient C; however, she failed to document its administration on the MAR or on the patient's recovery note.
 5. Ms. Chester signed out eleven (11) doses of Ativan 2 mg for administration to Patient A. The narcotics control sheet indicates that Ms. Chester made many corrections and changes in time, and is unclear as to exactly when she may have removed the medication for administration to Patient A. Further, Ms. Chester documented administration of only nine (9) doses of Ativan to Patient A on the MAR.
 6. At the conclusion of Ms. Chester's shift, she fell asleep when giving report, and could not find the appropriate line on which to sign her name on the narcotics

SANDRA CAROL STEVENSON CHESTER, R.N.

count sheet. Additionally, although she was shown by her coworker where to sign her name, Ms. Chester did not sign her name on the proper line.

- b. On or about June 15, 2001, while on duty, Ms. Chester altered Patient B's physician order for Morphine. Specifically, the physician wrote a new order for Morphine 2 mg IV every 4 hours as needed. Ms. Chester altered the MAR in that she changed the dosage from 2 mg to 4 mg.
- c. From approximately June 8 through June 13, 2001, Ms. Chester documented that she administered Morphine, in a higher dosage, on more occasions than the day shift to Patient B. During this period, Patient B was only administered Morphine 2 mg by the day shift on June 9, 2001. Ms. Chester documented that she administered Morphine 4 mg on nine (9) occasions while on duty.

On or about June 21, 2001, Ms. Chester's employment was terminated for acting outside the scope of her practice and license, specifically, injecting Lidocaine into her own toe and altering a physician's order for Morphine.

2. During the course of Ms. Chester's employment with Lewis Gale Medical Center, Salem, Virginia:
 - a. On or about July 26, 2001, Ms. Chester falsified her application for employment in that she failed to disclose her previous employment with Tazewell Community Hospital. As a result of the falsification, Ms. Chester's employment was terminated on December 11, 2001. On or about December 12, 2001, when staff cleaned out Ms. Chester's locker, the following was discovered:
 1. One syringe containing Morphine;
 2. One syringe containing Lidocaine;
 3. Two (2) Ultram tablets; and
 4. One Benadryl Allergy and Sinus Tablet.

SANDRA CAROL STEVENSON CHESTER, R.N.

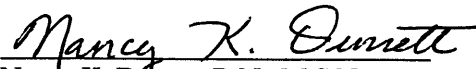
It was noted that items 3 and 4 above were in unit dose packaging with lot numbers that matched those of the hospital pharmacy.

- b. On or about October 29, 2001, during her shift, Ms. Chester signed out Morphine 2mg three (3) times, and Percocet 10mg once for Patient D. During the following shift, the patient received only Morphine on two (2) occasions.
 - c. On or about October 9, 2001, Patient E was given intravenous ("IV") fentanyl (Schedule II) via PCA pump at approximately 1100 hours. Ms. Chester changed the IV bag of fentanyl at midnight when 38 cc remained. It is unclear why Ms. Chester changed the medication early, and why she wasted, with a witness, the remaining 38 ccs.
 - d. From approximately October 9 through October 11, 2001, during her shifts, Ms. Chester signed out approximately 54mg of Morphine for Patient E. The patient had not received any pain medications, other than fentanyl via PCA pump, since October 6, 2001, and was not administered any pain medications other than fentanyl when Ms. Chester was not on duty. Further, on or about October 11, 2001, Ms. Chester failed to document the administration on the MAR of Morphine 10mg she signed out for the patient at 0000 hours.
3. On October 2, 2000, Ms. Chester signed a Participation Contract with the Health Practitioners' Intervention Program ("HPIP"). This was pursuant to Chapter 25.1 of Title 54.1 of the Code of Virginia (1950), as amended, and 18 VAC 76-10-10, et seq., of the Regulations Governing the Health Practitioners' Intervention Program, with the understanding that the program is to assist those persons who have an impairment, defined as "a physical or mental disability, including, but not limited to substance abuse, that substantially alters the ability of a practitioner to practice his profession with safety to his patients and the public." On December 6, 2000, Ms. Chester signed a Recovery Monitoring Contract with the HPIP. On June 15, 2001, Ms. Chester was dismissed from the HPIP due to her:

SANDRA CAROL STEVENSON CHESTER, R.N.

- a. Failure to enter and complete treatment as recommended;
 - b. Failure to call for or submit to urine drug screens;
 - c. Failure to respond to telephone messages and to written correspondence regarding non-compliance;
 - d. Failure to send in monthly self-reports; and
 - e. Failure to call her case manager weekly pursuant to her Recovery Monitoring Contract.
4. On or about August 15, 2001, the investigator from the Department of Health Professions interviewed Ms. Chester with regard to her dismissal from the HPIP. During the interview, Ms. Chester advised the following:
- a. She had not been employed since September 2000;
 - b. She denied use of narcotics;
 - c. She stated that Dr. Sutherland initially diagnosed her as being depressed with suicidal tendencies, and placed her on Prozac;
 - d. She is not in treatment;
 - e. She attended Aftercare meetings two (2) times a week at Highlands Community, Abingdon, Virginia;
 - f. She did not comply with the terms of her contract with the HPIP.
5. During the course of investigation into the above allegations, it was discovered that Ms. Chester failed to notify the HPIP of her employment with Tazewell Community Hospital, and did not inform this hospital of her contract with the HPIP.

FOR THE BOARD


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

ENTERED: June 25, 2002
5