



COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Nursing

April 1, 2002

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

Sandra Chester, R.N.
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Grundy, Virginia 24614

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CERTIFIED MAIL
71064575129435553284

RE: License No.: 0001-136680

Dear Ms. Chester:

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), (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 your employment with Tazewell Community Hospital, Tazewell, 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 you, became combative and attempted to get out of bed. You were on break, and when paged to return to the Intensive Care Unit immediately, you did not respond to the page and return to the unit.
 2. By your own admission, you self-injected Lidocaine into your toe for which you did not have a physician's order.
 3. You administered at 0200 hours and 0615 hours Morphine 4 mg (Opioid), a Schedule II controlled substance, to Patient B. You documented the administration of both doses of the Morphine on the Medication Administration Record ("MAR"); however, you failed to completely document the second dose on the MAR, administered at 0615 hours, and you

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did not document administration of the medication in the nurse's notes.

4. At 0600 hours, you signed out Morphine 2 mg for administration to Patient C; however, you failed to document the administration on the MAR or on the patient's recovery note that you administered the Morphine to the patient.
 5. You signed out eleven (11) doses of Ativan 2 mg to be administered to Patient A. The narcotics control sheet indicates that you made many corrections and changes in time and is unclear as to exactly when you may have removed the medication for administration to Patient A. Additionally, you signed the Ativan out at 0130 hours three (3) times, crossing out one of the three notations that you made. Further, you documented as having administered only nine (9) doses of Ativan to Patient A on the MAR.
 6. At the conclusion of your shift, you fell asleep when giving report, and could not find the appropriate line on which to sign your name on the narcotics count sheet. Additionally, when shown by your coworker where to sign your name, you did not sign your name on the line, and the signature appears "shaky."
- b. On or about June 15, 2001, while on duty, you altered Patient B's physician order for Morphine. Specifically, the physician wrote a new order for Morphine, which was for Morphine 2 mg IV every 4 hours as needed. You altered the MAR in that you changed the dosage from 2 mg to 4 mg.
 - c. From approximately June 8 through June 13, 2001, you administered Morphine, in a higher dosage on more occasions than the day shift to Patient B. Specifically, during this time frame, Patient B was only administered Morphine 2 mg by the day shift on June 9, 2001. You administered Morphine 4 mg on nine (9) occasions while on duty.

On or about June 19, 2001, your employment was terminated for injecting Lidocaine into your toe and for altering a physician's order for Morphine.

2. During the course of your employment with Lewis Gale Medical Center, Salem, Virginia:
 - a. On or about July 26, 2001, you falsified your application for employment in that you failed to disclose your previous employment with Tazewell Community Hospital. As a result of the falsification, your employment was terminated on December 11, 2001. On or about December 12, 2001, when staff cleaned out your 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.

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 and 30, 2001, during your shift, you administered Morphine 2 mg and Percocet 250 mg to Patient D. During the following 12-hour shift, the patient was only administered Morphine on two (2) occasions. Further, a review of Patient D's MAR revealed that on or about October 29 through 31, 2001, you signed out and documented as having administered two (2) to three (3) times more Morphine to be administered to Patient D that the day shift.
 - c. From approximately October 9 through October 31, 2001, during your shifts, you administered Morphine 10 mg to Patient E. The patient had not received any pain medications since October 6, 2001, and was not administered any pain medications when you were not on duty. Further, on or about October 11, 2001, you documented signing out Morphine 10 mg for the patient at 0000 hours; however, you failed to document the administration of the medication on the MAR.
 - d. On or about October 9, 2001, Patient E was given Fentanyl intravenous ("IV") at 1110 hours. You changed the IV bag of the Fentanyl (opioid), a Schedule II controlled substance, at midnite when 38 cc remained. It is unclear why you changed the medication early, and why you wasted, with a witness, the remaining 38 ccs.
3. On October 2, 2000, you signed a Participation Contract with the Health Practitioners' Intervention Program ("HPIP"), pursuant to Chapter 25.1 of Title 54.1 of the Code, and 18 VAC 76-10-10, et. seq., of the Regulations Governing the HPIP. On December 6, 2000, you signed a Recovery Monitoring Contract ("Contract"). On June 15, 2001, you were dismissed from the HPIP due to the following:
- 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 your case manager weekly pursuant to your contract.
4. On or about August 15, 2001, the investigator from the Department of Health Professions interviewed you with regard to your dismissal from the HPIP. During the interview, you advised the investigator of the following:
- a. You have not been employed since September 2000;
 - b. You denied use of narcotics;
 - c. You stated that Dr. Sutherland initially diagnosed you as being depressed with suicidal tendencies, and you were placed on Prozac.

- d. You are not in treatment.
 - e. You attend Aftercare meetings two (2) times a week at Highlands Community, Abingdon, Virginia.
 - f. You did not comply with the terms of your contract with the HPIP.
5. During the course of investigation into the above allegations, it was discovered that you failed to notify the HPIP of your employment with Tazewell Community Hospital, and you did not inform the Hospital of your contract with the HPIP.

After the conference, the conference committee is authorized to take 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 you on probation with such terms as it may deem appropriate;
- 3. The committee may reprimand you;
- 4. The committee may impose a monetary penalty pursuant to § 54.1-2401 of the Code; or
- 5. 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.

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) 662-9950 or by sending us a letter at the address listed above.

You have the right to information that the Board will rely upon in making a decision. Therefore, I have enclosed a copy of the documents that will be distributed to the members of the Committee. The Committee, when discussing the allegations with you and deliberating upon your case, will consider these documents. 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.

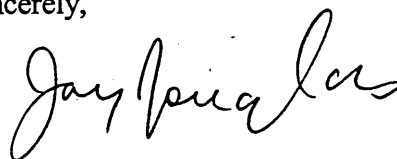
Also, enclosed are copies of the relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws and regulations relating to the practice of nursing

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in Virginia that are cited in this notice.

Sincerely,

A handwritten signature in black ink, appearing to read "Jay P. Douglas". The signature is fluid and cursive, with the first name "Jay" being more prominent.

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

JPD/alt/dl

Enclosures

cc: Robert A. Nebiker, Director, Department of Health Professions
James L. Banning, Director for Administrative Proceedings
Jennifer Baker, Investigator (Case No. 82095, 84047, 82696)
Loretta Hopson Bush, Investigator (Case No. 82095)
Donna P. Whitney, L.P.N., C.S.A.C, Intervention Program Committee Coordinator
Committee members
Gayle E. Miller, Senior Adjudication Analyst

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In order to protect the privacy of the individuals referred to in this case, they have been referred to by letters and are identified as follows:

Patient A: George Pearson

Patient B: Olive Goins

Patient C: Lillian Sage

Patient D: Estelle Kluck

Patient E: Tula Cox