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COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Nursing

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January 8, 2002

Julia K. Cash, R.N.
1978 Shutterlee Mill Road
Staunton, Va 24401

CERTIFIED MAIL
7106 4575 1294 3555 8456

RE: License No. 0001-143044

Dear Ms. Cash:

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 ("Code"), on February 7, 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 Term Numbers 1 and 2 of the Order entered August 25, 1998, § 54.1-3007(2), (3), (5), (6) and (8) of the Code, and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations of the Board of Nursing in that:

1. Pursuant to an Order entered August 25, 1998, disciplinary proceedings against your license were continued generally contingent upon your compliance with certain terms and conditions, to include participation and compliance 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. You failed to comply with the terms and conditions of the Order in that during July and September 2001, you had several positive drug screens. In September 2001, you enrolled in an intensive outpatient treatment program at Rockingham Memorial Hospital. On or about September 18, 2001, you tested positive for barbiturates and admitted administering one Fiorinal tablet. Subsequently, you were transferred to a residential treatment program at Harrison House.

2. During the course of your employment with Westminster Canterbury of the Blue Ridge, Charlottesville, Virginia:

a) On or about July 12, 2001, staff observed a personality change, noted that you were easily upset at minor changes in your routine, and that you appeared disheveled.

Virginia Monitoring, Inc., was notified and you were instructed to have a urine drug screen performed, which tested positive for opiates.

b) A subsequent medical records review revealed that you documented administration of one dose of three (3) Percocet tablets (oxycodone/acetaminophen, Schedule II) to Resident A; however, this resident was ordered only one Percocet tablet and regularly received only one tablet from all other nurses on the 3-11 shift. Further, Resident A was alert and oriented and reported receiving only one tablet each dose.

c) On or about July 23, 2001, your employment was terminated for misappropriation of patient property.

d) You falsified your application for employment dated February 27, 2001, in that you failed to list your employment with Sunnyside Retirement Community and Woodrow Wilson Rehabilitation Center and reasons for leaving.

3. On or about September 29, 2000, your employment was terminated with Sunnyside Retirement Community, Harrisonburg, Virginia, due to numerous medication/documentation errors, including but not limited to, the following incidents:

a) On or about September 27, 2000, you failed to document the administration of medications for two residents, on the chromodose record.

b) On or about September 23 and 24, 2000, you documented administering Aricept 10mg to a resident, when in fact, the pharmacy had not supplied the medication.

c) On or about August 27, 2000, you failed to properly document the administration of several medications and transcribe a new order onto the chromodose record.

d) On or about August 26, 2000, you failed to properly document the administration of Coumadin and Medrol.

e) On or about August 26, 2000, you documented administering a resident two Darvocet tablets (propoxyphene, Schedule IV), instead of one tablet as prescribed. The following shift administered one tablet as prescribed, which resulted in the resident being very sleepy.

f) On or about August 21, 2000, you documented the administration of bedtime doses of Ultram, Aricept and lorazepam (Schedule IV); however, the medications were later found in the medication drawer. Also, you failed to administer a Prozac capsule and eye solution which were found the next morning.

g) On or about August 10, 2000, you failed to administer a resident's nitro patch, which was ordered to be placed on at bedtime. It was later determined that the medication had not been supplied by the pharmacy; however, you failed to obtain a patch.

Additionally, the Committee will re-examine the allegations made in the notice of informal conference dated July 20, 1998, 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) of the Regulations of the Board of Nursing, in that:

4. During the course of your employment with the Woodrow Wilson Rehabilitation Center ("WWRC"), Fishersville, Virginia:

a) Between July 2, 1997 and August 2, 1997, you diverted various amounts of Ritalin (methylphenidate hydrochloride, Schedule II) and Dexedrine (dextroamphetamine,

Schedule II) for your personal and unauthorized use, from outpatient student prescriptions, to include the prescriptions belonging to Students A-H. You accomplished this diversion by entering the patient prescription stocks maintained on the student health unit, removing the drugs, and failing to chart any administration of these medications.

b) By your own admission, you have little memory of the spring and summer of 1997, as you were over-medicated on prescribed Xanax (alprazolam, Schedule IV), and acknowledged that you were impaired while on duty.

c) On July 5, 1997, you were counseled regarding your lethargic appearance and slurred speech at the end of your shift on July 2, 1997. Staff noted on other occasions that you were loud, evidenced scattered thinking, were unable to focus or concentrate, and had disjointed behavior. The pharmacist-in-charge at WWRC noted that you seemed to have very erratic, hyper behavior while on duty; and you informed her that you were self-administering Ritalin prescribed for your son.

d) On or about August 4, 1997, your employment was terminated for suspicion of drug diversion.

5. Between December 1996, and August 1997, you received prescriptions for oxycodone (Schedule II), hydrocodone (Schedule III), and Tylenol #3 (Schedule III) from four (4) physicians concomitantly. Between January 1997 and July 1997, you received Valium (diazepam, Schedule IV), and alprazolam, from two (2) physicians concurrently.

6. During the course of your employment with Continuing Care, Harrisonburg, Virginia, between August 1996 and December 1996:

a) On or about November 15, 1996, you were counseled for poor documentation, poor understanding of rules and regulations, non-compliance with home visits and tardy paperwork.

b) On or about November 18, 1996, you were counseled for being disorganized during a home visit, failing to maintain sterile field, and having to be reminded to do complete vital signs.

c) On or about November 24, 1996, you were counseled for failing to create a chart for a new patient and failing to assure that all medications were properly noted.

d) On or about December 10, 1996, you were removed from all visits and responsibilities and asked to provide all notes and visit documentation. On or about December 17, 1996, your employment was terminated.

e) By your own admission, you were fired because the duties of the position were "over your head."

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 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.

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, which will be relied upon by the Board in making a decision. Therefore, I have enclosed a copy of the documents, which 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

JPD/th/klb
Enclosures
cc: John W. Hasty, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Tammie D. Hall, Senior Adjudication Analyst
Katherine Wax, Probation Analyst (82365)
Pamela Twombly, Regional Investigative Supervisor (53359)
Donna P. Whitney, L.P.N., IPC Coordinator
Committee Members