I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

# Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.texas.gov
**Katherine A. Thomas, MN, RN, FAAN**
***Executive Director***

October 23, 2013

Certified Mail No. 91 7199 9991 7031 5251 9566
Return Receipt Requested

Lisa C. Akers
705 Village Way #1208
New Braunfels, TX 78130

Dear Ms. Akers:

Your Application for Prescriptive Authority For Advanced Practice Nurses, requesting a determination of eligibility for prescriptive authorization in compliance with Section 201.152 and 301.452, Texas Occupations Code, and the Board's Rules at 22 TEX. ADMIN. CODE Chapter 222, was considered by the Executive Director of the Board on October 11, 2013, pursuant to §§301.257, 301.452. You have been found to be ineligible for licensure as a nurse in the State of Texas based upon the grounds discussed below.

Our records indicate the following:

On or about December 17, 2012, your license to practice professional nursing in the State of Missouri were revoked through a Disciplinary Order by the State Board of Nursing, State of Missouri, Case Number 2011-002784 / AHC 12-0997 BN. A copy of the Missouri Disciplinary Order, including the Findings of Fact, Conclusions of Law, and Disciplinary Order dated December 17, 2012, is attached and incorporated herein by reference as part of this letter.

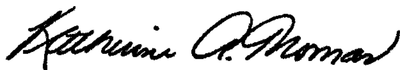
You are subject to denial of Application for Prescriptive Authority For Advanced Practice Nurses for this conduct pursuant to the following subsections of the Occupations Code §301.452(b):
...(8) revocation, suspension, or denial of, or any other action relating to, the person's license or privilege to practice nursing in another jurisdiction.

The Board also requires petitioners to demonstrate their ability to consistently conform to the requirements of the Nursing Practice Act, the Board's Rules and Regulations, and generally accepted standards of nursing practice; to possess good professional character; and to pose no threat to the health and safety of patients and the public. The Board has adopted a rules, located at 22 Tex. Admin. Code §213.27 - §213.33, that sets forth the factors and disciplinary and eligibility policies and guidelines that must be used in evaluating good professional character in eligibility and disciplinary matters. Based upon the factors specified in §213.27 - §213.33, you have failed to provide sufficient evidence of good professional character required by §213.27 - §213.33.

**Members of the Board**
Kristin Benton, MSN, RN, Austin, *President*
Deborah Bell, CLU, ChFC, Abilene · Patricia Clapp, BA, Dallas · Tamara Cowen, MSN, RN, Harlingen · Sheri Crosby, JD, SPHR, Dallas · Marilyn Davis, BSN, RN, MPA, Sugar Land · Richard Gibbs, LVN, Mesquite
Kathy Leader-Horn, LVN, Granbury · Mary M. LeBeck, MSN, RN, Weatherford · Josefina Lujan, PhD, RN, El Paso · Beverley Jean Nutall, LVN, Bryan · Kathleen Shipp, MSN, RN, FNP, Lubbock

Due to this denial, you have the right to a public hearing before an Administrative Law Judge with the State Office of Administrative Hearings. Should you decide to appeal the decision to deny your Application for Prescriptive Authority For Advanced Practice Nurses, please submit a written request for a public hearing, to the attention of Patricia Vianes-Cabrera, Executive Assistant, Office of General Counsel, 333 Guadalupe, Suite 3-460, Austin, Texas, 78701. Your written request to appeal this decision must be received in our office within sixty (60) days of the date of this letter. Further, if this office receives information regarding additional behavior that has not been previously disclosed to or discovered by this office, please be advised that evidence of such additional conduct or behavior may be used against you during the public hearing in this matter to show that you lack the good professional character and other requirements for Prescriptive Authority For Advanced Practice Nurses.

Sincerely,

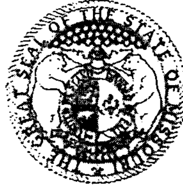


Katherine A. Thomas, MN, RN, FAAN
Executive Director

KT/151

Attachments: Missouri Disciplinary Order, including the Findings of Fact, Conclusions of Law, and Disciplinary Order, dated December 17, 2012.

s.wpd(12-08-2011)



Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Jane A. Rackers, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF NURSING
P.O. BOX 656, Jefferson City, MO 65102-0656
800-735-2966 TTY Relay Missouri 800-735-2466 Voice Relay Missouri

Web Site: http://pr.mo.gov/nursing.asp

Lori Scheidt
Executive Director
Telephone: 573-751-0681

December 18, 2012

Katherine Thomas, MN, RN, FAAN
Texas Board of Nursing
333 Guadalupe # 3 – 460
Austin Texas 78701

Re: *State Board of Nursing v. Lisa Akers, RN 150879*
*Case Number 2011-002784*

Dear Ms. Thomas:

This is to inform you that following a Disciplinary Hearing, the license of the above Licensee, was revoked. Attached is a copy of the Board Order issued to Ms. Akers at the hearing. This copy is being sent to you to take what action you deem necessary in your state.

The Board thanks you for your cooperation in this matter.

If you have any questions, please feel free to contact our office at (573) 751-0082.

Sincerely,

Lori Scheidt

Lori Scheidt, MBA-HCM
Executive Director

LS:bs

# AFFIDAVIT

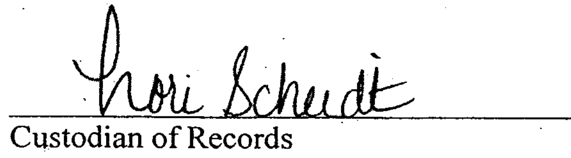
| | |
|---|---|
| MISSOURI STATE | ) |
| BOARD OF NURSING | ) |
| | ) |
| vs. | ) |
| | ) |
| LISA AKERS | ) |
| RN 150879 | ) |

Before me, the undersigned authority, personally appeared Lori Scheidt, who, being by me duly sworn, deposed as follows:

1. My name is Lori Scheidt. I am of sound mind, capable of making this affidavit and personally acquainted with the facts herein stated and would testify to them as true at any hearing regarding the attached records.

2. I am employed by the Missouri State Board of Nursing in Jefferson City, Missouri (hereinafter "Board"). I serve as the Executive Director. Attached hereto are 15 page(s) of records from the Board, which reflect records kept by the Board regarding **Lisa Akers**.

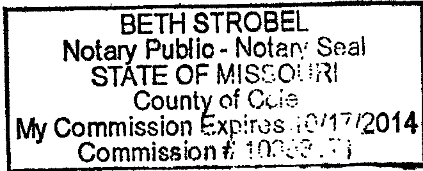
3. The 15 page(s) of records are kept by the Board in the regular course of business, and it was the regular course of business of the Board for an employee or representative of the Board with knowledge of the act, event condition, opinion or diagnosis recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time of the act, event, condition, opinion or diagnosis. The records attached hereto are the original, exact duplicates of the original, or accurate reproductions of the original records as permitted by section 490.692



Custodian of Records

In witness whereof I have hereunto subscribed by name and affixed my official seal this

18th day of December, 2012.




Notary Public
Cole County, Missouri

(Seal)

My Commission Expires October 17, 2014.

**BEFORE THE STATE BOARD OF NURSING**
**STATE OF MISSOURI**

| | | | |
|---|---|---|---|
| STATE BOARD OF NURSING, | ) | | |
| | ) | | |
| Petitioner, | ) | | |
| vs. | ) | Case Number | 2011-002784 |
| | ) | | AHC 12-0997 BN |
| LISA AKERS, | ) | | |
| | ) | | |
| Respondent. | ) | | |

**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCIPLINARY ORDER**

This Board filed a complaint with the Administrative Hearing Commission seeking authority to discipline the nursing license of Lisa Akers. The Administrative Hearing Commission (AHC) entered a default Decision in this matter on August 21, 2012, finding cause for this Board to discipline the nursing license of Lisa Akers. The Board convened a hearing on December 6, 2012, at its regular meeting in Jefferson City to determine what discipline, if any, should be imposed on Respondent's nursing license.

Respondent appeared by telephone without counsel. The Board was represented by Cotton Walker. Rodney Massman acted as legal advisor to the Board. Evidence was adduced, exhibits were received and the matter was taken under advisement. The Board now enters its findings of fact, conclusions of law and disciplinary order in this matter:

**FINDINGS OF FACT**

1. The State Board of Nursing (Board) is an agency of the State of Missouri created and established pursuant to §335.021 RSMo with the function of executing and enforcing the provisions of Chapter 335 RSMo, the Nursing Practice Act, for the purpose of safeguarding the public health.

2. The Board filed a complaint with the AHC to discipline Respondent Lisa Akers' nursing license, to which Respondent Lisa Akers did not file an answer or otherwise respond after being properly served. The AHC entered a default decision against her. All facts in the Board's complaint are therefore deemed admitted by Respondent. The AHC decision and complaint were admitted into evidence in this case.

3. Lisa Akers holds a license from this Board as a registered professional nurse, RN 150879. Respondent's license was current and active at all times relevant herein. Respondent has also been an APRN.

4. Respondent was employed as a registered professional nurse with Ste. Genevieve County Memorial Hospital, in Ste. Genevieve, Missouri from May 26, 2010 through March 7, 2011.

5. Respondent worked at Bloomsdale Family Health Clinic, an off campus clinic of Ste. Genevieve County Memorial Hospital.

6. On January 24, 2011, a patient that was seen by Respondent was prescribed Augmentin and Tessalon Perles. Neither medication was listed in the patient's medication list.

7. This patient returned for a visit on February 4, 2011 and was given another prescription.

8. On January 26, 2011, a husband and wife were seen by Respondent and were prescribed antibiotics from the dispensary system. Neither prescription had dosing instructions on the bottle, and the husband's bottle had the wrong last name on it.

9. On February 4, 2011, staff gave Respondent a detailed note to create a

work excuse on a certain patient and the note Respondent created was for the wrong patient.

10. On February 9, 2011, Respondent failed to address a faxed medication refill request for Klein's Pharmacy from February 3, 2011 and February 9, 2011.

11. On the evening of February 10, 2011, Respondent saw three patients.

12. On February 10, 2011, Respondent saw patient, N.E., but failed to order and call in two medications for the patient at Klein's Pharmacy.

13. On February 11, 2011, there was a discrepancy with the in-house inventory.

14. Upon further investigation it was determined that on January 24, 2011 Respondent entered a prescription of antibiotics that she dispensed to patient, M.H., for bronchitis and otitis media.

15. Respondent also dispensed a course of Augmentin from the in-house inventory but failed to update the easyscript website.

16. On February 14, 2011, Respondent saw a child and ordered Omnicef through the Electronic Medical Records (EMR), which automatically documents in the patient's office note.

17. Later in the evening on February 14, 2011, Respondent typed her plan which stated the child was given Augmentin.

18. Staff reported that Respondent had the following issues in one day.

a. At 3:00 p.m., Respondent saw her first patient for the day. The child came in with a temperature of 104.2. Respondent failed to assess the patient, but instead proceeded to have a conversation with a drug representative.

b. Staff informed Respondent that patient, R.S., needed a prescription refill (only message Respondent received). Respondent failed to call in the prescription for the patient.

c. A patient was sent to the hospital for a bone density and Respondent diagnosed as a hyperthyroidism. Diagnosis had to be amended by staff (2nd time in a week).

d. Respondent threw away papers with a patient's name on it in a regular trash instead of shredding them.

19. Patient, E.F., was seen by Respondent for the second time for a fever. Respondent failed to call in medication to the pharmacy and failed to add the medication to the patient's medication list.

20. Respondent received several counseling sessions regarding the importance of accurate documentation.

21. Respondent was given plenty of resources and education to prevent erroneous medication orders from occurring.

22. Respondent's conduct as described herein resulted in her patients not receiving proper medications in time and delayed care.

23. Respondent has a duty to ensure proper treatment of her patients.

24. Respondent has a duty to accurately document medications dispensed to patients and make sure the medications are called in for patients.

25. Respondent's conduct demonstrates a conscious disregard for the health and safety of her patients and a failure to act in the best interest of her patients, placing her patients and the public in imminent danger.

26. Respondent's conduct demonstrates a lack of, failure or inability of Respondent to utilize the knowledge, judgment, and skills required of a nurse to protect

the health and safety of her patients and a failure to act in the best interest of her patients.

27. Respondent failed to use her professional nursing judgment to act in the best interest of her patients.

28. Respondent's employment with Ste. Genevieve County Memorial Hospital was terminated as a result of the above events on March 7, 2011.

29. Respondent received several counseling sessions about proper documentation as an RN and the importance of making sure her documentation was accurate. Respondent continued to make mistakes and failed to call in prescriptions for her patients. Her multiple failures noted above as an RN display a pattern of incompetent behavior as an RN, and a violation of professional trust, and gross negligence.

**CONCLUSIONS OF LAW**

1. The Board has jurisdiction to discipline Respondent's license pursuant to the provisions of §335.066.2(5) and (12) RSMo, which provides:

> 2. The Board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> > (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
> >
> > . . .

(12) Violation of any professional trust or confidence,[.]

2. The Board has jurisdiction to discipline Respondent's license pursuant to §335.066.3 RSMo, which provides:

> After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621, RSMo. Upon a finding by the administrative hearing commission that the grounds provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit.

3. The AHC found in its decision of August 21, 2012 that there was cause to discipline Respondent's license based on incompetency, gross negligence, and violation of professional trust for failing to correctly administer and document medications pursuant to §355.066.2(5) and (12).

4. "[G]rounds for discipline specified in such a professional-licensing statute should be liberally construed to protect the public." Professional licensing statutes are not penal in nature and the "powers conferred upon boards of health to enable them effectively to perform their important functions in safeguarding the public health should receive a liberal construction." *Koetting v. Bd. of Nursing*, 314 S.W.3d 812, 819 (Mo. App. 2010).

## ANALYSIS

The AHC found that Respondent violated a professional trust and committed gross negligence and incompetency in the profession of a nurse when she continually made mistakes and errors with her patients even after being counseled.

She also violated the drug laws of the state by failing to call in prescriptions or record correctly what medication was being ordered for particular patients. At the Board's hearing, Respondent did not offer any mitigating evidence as to any of these errors and mistakes, and the Board did not find her testimony persuasive. Respondent did not take responsibility for her actions. Respondent had previous counseling and also claimed that she was simply "too busy" when she only had a few patients on some days. Respondent further testified that even after this employment in Missouri, that while employed as a nurse in Texas, her employer in Texas even encouraged her to seek employment elsewhere and she quit. The Board notes that the Respondent was given ample opportunity to present her testimony and evidence to both this Board and the Administrative Hearing Commission, and did not defend her conduct at the Administrative Hearing Commission at all. Therefore, the AHC found her license was subject to discipline.

The Board is charged with executing and enforcing the Nursing Practice Act for the purpose of safeguarding the health of the public. The Board therefore finds and concludes that the appropriate level of discipline for the license of Lisa Akers is revocation in order to safeguard the health of the public.

## DISCIPLINARY ORDER

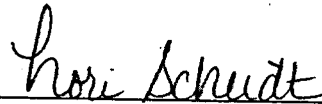
1. The Missouri State Board of Nursing enters its Order and **REVOKES** the nursing license of Respondent, Lisa Akers, RN 150879.

2. The Board will maintain this Order as an open and public record of the Board as provided in Chapters 335, 610 and 620, RSMo. The Board will report this Order to data banks, other appropriate entities and in its newsletter. This is a

disciplinary action against Respondent's license. The original of this document shall be kept in the Board's file and its contents shall be disclosed to the public upon proper request.

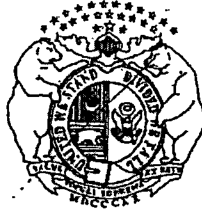
**ENTERED THIS 17th DAY OF DECEMBER 2012.**

**STATE BOARD OF NURSING**



Lori Scheidt
Executive Director

# Before the Administrative Hearing Commission State of Missouri



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| STATE BOARD OF NURSING, | ) | |
| | ) | |
| Petitioner, | ) | |
| | ) | |
| vs. | ) | No. 12-0997 BN |
| | ) | |
| LISA AKERS, | ) | |
| | ) | |
| Respondent. | ) | |

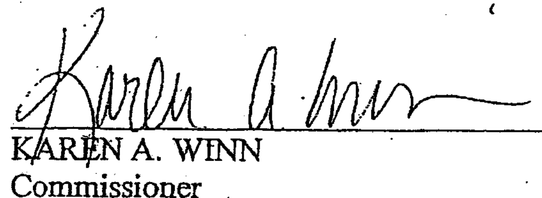
**DEFAULT DECISION**

On June 7, 2012, Petitioner filed a properly pled complaint seeking to discipline Respondent. Respondent was served with a copy of the complaint and our notice of complaint/notice of hearing by certified mail on July 18, 2012.

More than thirty days have elapsed since Respondent was served. Respondent has not filed an answer or otherwise responded to the complaint. On August 20, 2012, Petitioner filed a motion to enter a default decision.

In accordance with § 621.100.2,[1] we enter a default decision against Respondent establishing that Petitioner has cause to discipline Respondent under § 335.066.2(5) and (12), RSMo. This default decision shall become final and will not be set aside unless a motion is filed with this Commission within thirty days of the date of this order establishing good cause for not responding to the complaint and stating facts constituting a meritorious defense.

SO ORDERED on August 21, 2012.



KAREN A. WINN
Commissioner

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[1]RSMo Supp. 2011.

BEFORE THE ADMINISTRATIVE HEARING COMMISSION
STATE OF MISSOURI

**FILED**

JUN 07 2012

ADMINISTRATIVE HEARING COMMISSION

| | | |
|---|---|---|
| **MISSOURI STATE BOARD OF NURSING**<br>**3605 Missouri Boulevard**<br>**P. O. Box 656**<br>**Jefferson City, MO 65102**<br>***Petitioner,*** | ) | |
| ***vs.*** | ) | **Case No. 120997 BN** |
| **LISA AKERS**<br>**P. O. Box 310934**<br>**New Braunfels, Texas 78131**<br>***Respondent.*** | ) | |

**COMPLAINT**

COMES NOW Petitioner, the Missouri State Board of Nursing ("Board"), by and through its attorney, Stephan Cotton Walker, for its cause of action against Respondent, Lisa Akers ("Respondent"), states the following:

1. The Missouri State Board of Nursing is an agency of the State of Missouri created and established pursuant to §335.021, RSMo, for the purpose of executing and enforcing the provisions of Chapter 335, RSMo, the Nursing Practice Act.

2. Based on information and belief, Respondent's address is P. O. Box 310934, New Braunfels, Texas 78131.

3. Respondent is licensed by the Board as a registered professional nurse in the State of Missouri, license RN 150879.

4. Respondent's Missouri nursing license number RN 150879 is current and active and was so at all relevant times herein.

5. Jurisdiction and venue are proper before the Administrative Hearing Commission

pursuant to §621.045, RSMo., and §335.066, RSMo.

6. Respondent was employed as a registered professional nurse with Ste. Genevieve County Memorial Hospital, Ste. Genevieve, Missouri from May 26, 2010 through March 7, 2011.

7. Respondent worked at Bloomsdale Family Health Clinic, an off campus clinic with Ste. Genevieve County Memorial Hospital.

8. On January 24, 2011, a patient that was seen by Respondent was prescribed Augmentin and Tesslon Perles. Neither medication was listed in the patient's medication list.

9. This patient returned for a visit on February 4, 2011 and was given another prescription.

10. On January 26, 2011, a husband and wife were seen by Respondent and were prescribed antibiotics from the dispensary system. Neither prescription had dosing instructions on the bottle and the husband's bottle had the wrong last name on it (Kettinger instead of Gettinger).

11. On February 4, 2011, staff gave Respondent a detailed note to create a work excuse on a certain patient and the note Respondent created was for the wrong patient.

12. On February 9, 2011, Respondent failed to address a faxed medication refill request for Klein's Pharmacy from February 3, 2011 and February 9, 2011.

13. On the evening of February 10, 2011, Respondent saw three patients.

14. On February 10, 2011, Respondent saw patient, N.E., but failed to order and call in two medications for the patient at Klein's Pharmacy.

15. On February 11, 2011, there was a discrepancy with the in-house inventory.

16. Upon further investigation it was determined that on January 24, 2011 Respondent entered a prescription of antibiotics that she dispensed to patient, M.H., for bronchitis and otitis media.

17. Respondent also dispensed a course of Augmentin from the in-house inventory but failed to update the easyscript website.

18. On February 14, 2011, Respondent saw a child and ordered Omnicef through the Electronic Medical Records (EMR), which automatically documents in the patient's office note.

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b. Staff informed Respondent that patient, R.S., needed a prescription refill (only message Respondent received). Respondent failed to call in the prescription for the patient.

c. A patient was sent to the hospital for a bone density and Respondent diagnosed as a hyperthyroidism. Diagnosis had to be amended by staff (2nd time in a week).

d. Respondent threw away papers with a patient's name on it in a regular trash instead of shredding them.

21. Patient, E.F., was seen by Respondent for the second time for a fever. Respondent failed to call in medication to the pharmacy and failed to add the medication to the patient's medication list.

22. Respondent received several counseling sessions regarding the importance of accurate documentation.

23. Respondent was given plenty of resources and education to prevent erroneous medication orders from occurring.

24. Respondent's conduct as described herein resulted in her patients not receiving proper

medications in time and delayed care.

25. Respondent has a duty to ensure proper treatment of her patients.

26. Respondent has a duty to accurately document medications dispensed to patients and make sure the medications are called in for patients.

27. Respondent's conduct demonstrates a conscious disregard for the health and safety of her patients and a failure to act in the best interest of her patients, placing her patients and the public in imminent danger.

28. Respondent's conduct demonstrates a lack of, failure or inability of Respondent to utilize the knowledge, judgment, and skills required of a nurse to protect the health and safety of her patients and a failure to act in the best interest of her patients.

29. Respondent failed to use her professional nursing judgment to act in the best interest of her patients.

30. Respondent's employment with Ste. Genevieve County Memorial Hospital was terminated on March 7, 2011.

31. Cause exists for the Board to take disciplinary action against Respondent's nursing license number 150879 for violations of §§335.066.2(5), RSMo., and 335.066.2(12), RSMo.

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession

licensed or regulated by sections 335.011 to 335.096;

(12) Violation of any professional trust or confidence;

32. Respondent received several counseling sessions about proper documentation and the importance of making sure her documentation was accurate. Respondent continued to make mistakes and failed to call in prescriptions for her patients. Her multiple failures display a pattern of incompetent behavior as an RN.

33. Respondent's conduct as alleged herein constitutes misconduct, incompetency, and gross negligence, in the performance of the functions and duties of a nurse, warranting the imposition of discipline against her license under §335.066.2(5), RSMo.

34. Respondent's conduct as alleged herein constitutes a violation of professional trust or confidence, warranting the imposition of discipline against her license under §335.066.2(12), RSMo.

**WHEREFORE**, Petitioner respectfully requests this Commission to conduct a hearing in this cause pursuant to Chapter 621, RSMo, and thereafter to issue its findings of fact and conclusions of law, determining that Petitioner may take disciplinary action against Respondent's nursing license number 150879 for violation of Chapter 335, RSMo., and for such other and further relief as this Commission deems just and proper under the circumstances.