BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Vocational	§	AGREED
Nurse License Number 117630	§	
issued to SANDRA LOUISE RHODES	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of SANDRA LOUISE RHODES, Vocational Nurse License Number 117630, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was provided to Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent's license to practice Vocational Nursing in the State of Texas is currently in delinquent status.

4. Respondent received a Certificate in Vocational Nursing from Central Texas College, Killeen, Texas on December 13, 1986. Respondent was licensed to practice vocational nursing in the State of Texas on May 20, 1987.

5. Respondent's complete nursing employment history is unknown.

6. On or about November 9, 2012, Respondent was issued a Default Decision by the Administrative Hearing Commission, State of Missouri wherein the Missouri State Board of Nursing was authorized to take disciplinary action on Respondent's license to practice practical nursing in the State of Missouri. Subsequently, on or about March 25, 2013, Respondent was issued a Findings of Fact, Conclusions of Law, and Disciplinary Order by the Missouri State Board of Nursing wherein Respondent's license to practice practical nursing in the State of Missouri was placed on Probation for a period of two (2) years with terms and conditions. On or about September 11, 2013, Respondent was issued Findings of Fact, Conclusions of Law, and Disciplinary Order by the Missouri State Board of Nursing wherein Respondent's license to practice professional nursing in the State of Missouri was Revoked for failure to comply with the Findings of Fact, Conclusions of Law, and Disciplinary Order by the Missouri State Board of Nursing, dated March 25, 2013. Copies of the Default Decision issued by the Administrative Hearing Commission, State of Missouri, dated November 9, 2012, Findings of Fact, Conclusions of Law, and Disciplinary Order issue by the Missouri State Board of Nursing, dated March 25, 2013, and Findings of Fact, Conclusions of Law, and Disciplinary Order issued by the Missouri State Board of Nursing, dated September 11, 2013, are attached and incorporated by reference as part of this Order.

7. Formal Charges were filed on October 9, 2013.

8. Formal Charges were mailed to Respondent on October 10, 2013.

9. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license(s) to practice nursing in the State of Texas.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 117630, heretofore issued to SANDRA LOUISE RHODES, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Vocational Nurse License Number 117630, heretofore issued to SANDRA LOUISE RHODES, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying herself as a vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a vocational nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 13 day of Dec, 2013.

Sandra Rhodes

SANDRA LOUISE RHODES, Respondent

Sworn to and subscribed before me this 13 day of December, 2013

SEAL

LINDA J. ARGUMOSA
COMM. # 1981659
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
MY COMM. EXP. DEC. 23, 2016

Notary Public in and for the State of California

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Vocational Nurse License Number 117630, previously issued to SANDRA LOUISE RHODES.

Effective this 16th day of December, 2013.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

I certify this to be a true copy of the records on file with the Texas Board of Nursing.

Signed: _____

Date: _____

Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 12-1114 BN
	)	
SANDRA RHODES,	)	
	)	
Respondent.	)	

DEFAULT DECISION

On June 20, 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 August 23, 2012.

More than thirty days have elapsed since Respondent was served. Respondent has not filed an answer or otherwise responded to the complaint. On October 16, 2012, Petitioner filed a motion to enter a default decision. We gave Respondent until November 1, 2012, to respond, but she did not respond.

In accordance with § 621.100.2,[1] we enter a default decision against Respondent establishing that Petitioner is entitled to the relief requested in the complaint. This default decision shall become final and may 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 November 9, 2012.

Sreenivasa Rao Dandamudi

SREENIVASA RAO DANDAMUDI
Commissioner

[1]RSMo Supp. 2011.

BEFORE THE ADMINISTRATIVE HEARING COMMISSION
STATE OF MISSOURI

FILED

JUN 20 2012

ADMINISTRATIVE HEARING COMMISSION

MISSOURI STATE BOARD OF NURSING)
3605 Missouri Boulevard)
P. O. Box 656)
Jefferson City, MO 65102)
Petitioner,)
)
vs.) Case No. 12-1114 BN
)
SANDRA RHODES)
2001 SW 8th Street, Apt. A)
Blue Springs, Missouri 64015)
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, Sandra Rhodes ("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 resides at 2001 SW 8th Street, Apt. A, Blue Springs, Missouri 64015.

3. Respondent is licensed by the Board as a licensed practical nurse in the State of Missouri, license LPN 2009010471

4. Respondent's Missouri nursing license number LPN 2009010471 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 licensed practical nurse with Timberlake Care Center, Kansas City, Missouri from July 30, 2010 until April 5, 2011.

7. Respondent worked mostly the night shift from 7:00 p.m. one day to 7:00 a.m. the following morning.

8. A patient of Timberlake had an order for their dressing to be changed every day. The dressing was set up to be changed on the night shift.

9. In March an investigation into why the patient's wound was getting worse instead of better was conducted.

10. On March 19, 2011, a culture was done on the patient's wound which showed the growth of E. Coli. Antibiotics were started immediately.

11. It was later determined that Respondent failed to change this patient's dressing as directed by the physician during her shift.

12. At this time a state inspector was on site and considered giving the facility an immediate jeopardy deficiency based on the patient's wound condition.

13. During the inspection of the facility it was also discovered that there were other patients with old wound bandages that had not been changed.

14. V.W., Director of Nursing, performed a further investigation into the Medication Administration Records (MAR) and charts of these patients.

15. V.W. was able to determine based on the patient's records and other evidence that Respondent was responsible for changing the dressing for these patients, although treatment was not being done.

16. When a bandage is changed on a patient, the nurse changing the bandage will initial

and date the bandage indicating when it had been changed

17. Respondent worked from 7:00 p.m. March 21, 2011 to 7:00 a.m. March 22, 2011 and was responsible for patient, L.B.

18. Respondent initialed on patient, L.B.'s, MAR that she changed the patient's dressing during her shift.

19. The dressing that was found on patient, L.B., during the next shift (March 23, 2011 to March 24, 2011) was the dressing from March 20, 2011, which was dated and initialed by C.S.

20. Respondent worked March 25, 2011, March 26, 2011, and March 27, 2011. She was responsible for patient, L.B.

21. Respondent initialed on patient, L.B.'s, MAR that she changed the patient's dressing during her shift.

22. The dressing that was found on patient, L.B., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 23, 2011, which was dated and initialed by C.S.

23. Respondent worked March 25, 2011, March 26, 2011, and March 27, 2011. She was responsible for patient, A.D.

24. Respondent initialed on patient, A.D.'s, MAR that she changed the patient's dressing during her shift.

25. The dressing that was found on patient, A.D., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 24, 2011.

26. Respondent worked from 7:00 p.m. March 30, 2011 to 7:00 a.m. April 1, 2011 and was responsible for patient, A.D.

27. Respondent initialed on patient, A.D.'s, MAR that she changed the patient's dressing during her shift.

28. The dressing that was found on patient, A.D., during the next shift (April 1, 2011 to April 3, 2011) was the dressing from March 29, 2011, which was dated and initialed by C.S.

29. On several different patients, Respondent indicated in their charts that they received their medications and/or tube feeding medications.

30. In reviewing the patient's MAR and their medication bubble packs, V.W. was able to determine that these patients were not getting their medications during Respondent's shifts.

31. Respondent had a duty to follow physician's orders and give medication to her patients at times when directed.

32. Respondent's conduct as described herein resulted in her patients not receiving proper treatment of their wounds, their scheduled medications, and delayed care.

33. Respondent has a duty to change wound bandages for patients as ordered by their physicians to ensure proper treatment and to avoid infection of the wound.

34. Respondent failed to follow physician's orders by not changing wound bandages during her shifts as directed by the physician.

35. Respondent in her capacity as a nurse was responsible for assuring continuous nursing care to her patients by changing wound bandages during her shifts as directed by the physician.

36. Respondent has a duty to administer medications to her patients as ordered by their physicians and document the administration of those medications accurately.

37. Respondent failed to follow physician's orders by administering medications to her patients and then documenting the administration of those medications accurately.

38. Respondent in her capacity as a nurse was responsible for assuring continuous nursing care to her patients and accurate medication administration and documentation.

39. 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.

40. 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.

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

42. Respondent's employment with Timberlake Care Center was terminated on April 5, 2011.

43. Cause exists for the Board to take disciplinary action against Respondent's nursing license number 2009010471 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;

44. Respondent fabricated entries in the MAR to cover up her failure to administer medications to patients and her failure to change wound bandages as directed by their physicians. These fabricated entries were misrepresentations, and her conduct in making them was dishonest and

amounted to misconduct. Failing to give medications to patients and failing to change wound bandages as directed on numerous occasions demonstrated an egregious indifference to her professional duties. Her multiple failures to do so display a pattern of incompetent behavior as an LPN.

45. Respondent's conduct as alleged herein constitutes misconduct, incompetency, gross negligence, misrepresentation, dishonesty, and fraud 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.

46. 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 2009010471 for violation of Chapter 335, RSMo., and for such other and further relief as this Commission deems just and proper under the circumstances.

Respectfully submitted,

COTTON WALKER & ASSOCIATES

Stephan Cotton Walker #38899
Elm Court Plaza
1739 East Elm Street, Suite 101
Jefferson City, MO 65101
(573) 635-9200 FAX (573) 635- 6584
Attorney for Petitioner

BEFORE THE STATE BOARD OF NURSING
STATE OF MISSOURI

STATE BOARD OF NURSING, Petitioner,	)	
vs.	)	Case Number 2011-001939 12-1114 BN
SANDRA RHODES, Respondent.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCIPLINARY ORDER

This Board ('Board') filed a complaint with the Administrative Hearing Commission ("AHC") seeking authority to discipline the nursing license of Sandra Rhodes. The Administrative Hearing Commission entered a Default Decision in this matter on November 9, 2012, finding cause for this Board to discipline the nursing license of Sandra Rhodes. The Board convened a hearing on March 7, 2013, at its regular meeting in Jefferson City to determine what discipline, if any, should be imposed on Respondent's nursing license.

Respondent appeared in person and was not represented by 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. Sandra Rhodes holds a license from this Board as a licensed practical nurse, PN 2009010471. Respondent's license was current and active at all times relevant herein.

3. The AHC entered a default decision in this matter on November 9, 2012, finding that the Board was entitled to the relief requested in its complaint and therefore consequently that there was cause to discipline Respondent's license.

4. Respondent was employed as a licensed practical nurse with Timberlake Care Center in Kansas City, Missouri from July 30, 2010 until April 5, 2011.

5. Respondent worked mostly the night shift from 7:00 p.m. one day to 7:00 a.m. the following morning.

6. A patient of Timberlake had an order for a dressing to be changed every day. The dressing was set up to be changed on the night shift.

7. In March, 2011, an investigation into why the patient's wound was getting worse instead of better was conducted.

8. On March 19, 2011, a culture was done on the patient's wound which showed the growth of E Coli. Antibiotics were started immediately.

9. It was later determined that Respondent failed to change this patient's dressing as directed by the physician during her shift.

10. At this time a state inspector was on site and considered giving the facility an "immediate jeopardy" deficiency based on the patient's wound condition.

11. During the inspection of the facility it was also discovered that there were

other patients with old wound bandages that had not been changed.

12. V.W., the Director of Nursing, performed a further investigation into the Medication Administration Records (MAR) and charts of these patients.

13. V.W. was able to determine, based on the patient's records and other evidence, that Respondent was responsible for changing the dressing for these patients, although treatment was not being done.

14. When a bandage is changed on a patient, the nurse changing the bandage will initial and date the bandage indicating when it had been changed

15. Respondent worked from 7:00 p.m. March 21, 2011, to 7:00 a.m. March 22, 2011, and was responsible for patient, L.B.

16. Respondent initialed on patient, L.B.'s, MAR that she changed the patient's dressing during her shift.

17. The dressing that was found on patient, L.B., during the shift of March 23, 2011 to March 24, 2011 was the dressing from March 20, 2011, which was dated and initialed by C.S.

18. Respondent worked March 25, 2011, March 26, 2011, and March 27, 2011. She was responsible for patient, L.B.

19. Respondent initialed on patient, L.B.'s, MAR that she changed the patient's dressing during her shift.

20. The dressing that was found on patient, L.B., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 23, 2011, which was dated and initialed by C.S.

21. Respondent worked March 25, 2011, March 26, 2011, and March 27,

2011. She was responsible for patient, A.D.

22. Respondent initialed on patient, A.D.'s, MAR that she changed the patient's dressing during her shift.

23. The dressing that was found on patient, A.D., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 24, 2011.

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26. The dressing that was found on patient, A.D., during the next night shift (April 1, 2011, to April 3, 2011) was the dressing from March 29, 2011, which was dated and initialed by C.S.

27. On several different patients, Respondent indicated in their charts that they received their medications and/or tube feeding medications.

28. In reviewing the patient's MAR and their medication bubble packs, V.W. was able to determine that these patients were not getting their medications during Respondent's shifts.

29. Respondent had a duty to follow physician's orders and give medication to her patients at times when directed.

30. Respondent's conduct, as described herein, resulted in her patients not receiving proper treatment of their wounds, their scheduled medications, and delayed care.

31. Respondent has a duty to change wound bandages for patients as

ordered by their physicians to ensure proper treatment and to avoid infection of the wound.

32. Respondent failed to follow physician's orders by not changing wound bandages during her shifts as directed by the physician.

33. Respondent in her capacity as a nurse was responsible for assuring continuous nursing care to her patients by changing wound bandages during her shifts as directed by the physician.

34. Respondent has a duty to administer medications to her patients as ordered by their physicians and document the administration of those medications accurately.

35. Respondent failed to follow physician's orders by administering medications to her patients and then documenting the administration of those medications accurately.

36. Respondent in her capacity as a nurse was responsible for assuring continuous nursing care to her patients and accurate medication administration and documentation.

37. 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.

38. 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.

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

40. Respondent's conduct amounts to misconduct, incompetency, gross negligence, misrepresentation, dishonesty, fraud, and violation of a professional trust.

41. Respondent's employment with Timberlake Care Center was terminated on April 5, 2011.

42. Respondent's testimony that she did not know why she was terminated and her various explanations for what happened at the Care Center are found not credible.

43. The Board finds that this Disciplinary Order is issued to safeguard the public health.

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. "[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).

4. The AHC found in its default decision against Respondent that there was cause to discipline Respondent's license.

ANALYSIS

Respondent testified at the hearing that she had only heard about missing dressing changes from a co-worker. She also admitted that it was possible that she missed a dressing change because "she is human." Respondent did not directly address specifically any of the failure to change dressing incidents found against her, but generally testified that she would not do that. The Board finds her statements not credible and notes that Respondent did not contest or appear at any of the proceedings

before the administrative hearing commission. The Board also notes Respondent states she was confused by the process, but gave no specific reasons as to why. Basic patient care in the routine of dressing changes is a fundamental duty of nursing. To leave soiled dressings and to not change them is a grave disservice to patients, colleagues and Respondent's employer. The Board is concerned about Respondent's conduct in this regard, and finds that further monitoring is required.

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 Sandra Rhodes is probation in order to safeguard the health of the public.

DISCIPLINARY ORDER

1. The Missouri State Board of Nursing enters its Order and places the nursing license of Respondent, Sandra Rhodes, PN 2009010471, on **PROBATION** for a period of two (2) years on the following terms and conditions:

GENERAL REQUIREMENTS

A. Respondent/Licensee shall meet with the Board or its professional staff at such times and places as required by the Board. The Board shall provide Licensee with notice of the dates, times and locations of regularly scheduled meetings at the time this executed Order is provided to Licensee. If Licensee does not receive notice of the dates, times and locations of her regularly scheduled meeting with the Board within one (1) month after the effective date of this Order, Licensee shall contact the Board office at: **Missouri State Board of Nursing, P.O. Box 656, Jefferson City, Missouri 65102, or by telephone at: (573) 751-0681.** In addition to these regularly scheduled meetings, Licensee shall meet with the Board or its professional staff at any other time, as required by the Board.

B. Licensee shall meet in person with the Board's Discipline Administrator to review the terms and conditions of the probation at

such date, time and place as designated by the Board's Discipline Administrator.

C. Licensee shall submit documents showing compliance with the requirements of this Order to the Board when requested and within the time limit the Board requests.

D. Licensee shall inform the Board within ten (10) working days of any change of home address or home telephone number.

E. Licensee shall not violate the Nursing Practice Act, Chapter 335 RSMo, as amended, shall renew her license within five (5) working days and shall not allow her license to lapse. Licensee may place her license on inactive or retired status. The conditions of discipline will continue to apply if the license is inactive or retired.

F. Licensee shall bear all costs of complying with this Order.

G. Licensee shall obey all federal, state and local laws, and all rules and regulations governing the practice of nursing in this state.

H. Licensee is responsible for insuring that all quarterly reports due pursuant to these conditions are submitted to the Board on a quarterly basis.

EMPLOYMENT REQUIREMENTS

A. Licensee shall keep the State Board of Nursing informed of her current place of employment and of any changes in her place of employment by notifying the Board within ten (10) working days of such a change. This form is located at http://pr.mo.gov/boards/nursing/Change-Form.pdf

B. Licensee shall provide a copy of this Order to any current employer and to any potential employer. Licensee shall provide a copy of this Order to her current employer as soon as she receives it and no later than during her next work shift or her employer's next working day, whichever is sooner. In addition, Licensee shall provide a copy of this Order to any potential employer prior to acceptance of any offer of employment.

C. Licensee shall cause an evaluation, using the form supplied by the Board, from each and every employer to be completed for the Board at least quarterly, with due dates to be determined by the Board. The evaluation form shall be completed by Licensee's supervisor within a four-week period prior to the date it is due. If Licensee ends employment with an employer, Licensee shall, in addition, request that a final evaluation form from that supervisor to be submitted to the Board within a six-week period

following the last day of employment. This evaluation shall be an evaluation of Licensee's job performance and shall be sent to: State Board of Nursing, ATTN: Discipline Administrator, P.O. Box 656, Jefferson City, Missouri 65102. The preferred method of submitting the evaluation is that the evaluation is sent directly by the employer. The Licensee may submit the form to the Board; however, Board staff may verify with the employer the authenticity of the evaluation submitted by Licensee. This form may be found at http://pr.mo.gov/nursing-monitoring.asp

D. If Licensee is not employed at any time during the period of discipline, Licensee shall instead submit a form "Statement of Unemployment" stating the period(s) of unemployment. This form is located on the Board of Nursing Website at the address provided in paragraph C above.

E. Licensee shall execute any release or provide any other authorization necessary for the Board to obtain records of Licensee's employment during the period covered by this Order.

EMPLOYMENT RESTRICTIONS

A. Licensee may not serve on the administrative staff, as a member of the faculty or as a preceptor at any school of professional or practical nursing.

B. Licensee shall only work as a nurse where there is on-site supervision. Licensee shall not work in home health care, hospice or durable medical equipment.

C. Licensee shall not work in a healthcare-related position for a temporary employment agency or as a healthcare related independent contractor.

CONTINUING EDUCATION

A. Licensee shall complete the following classes offered at http://learningext.com/ groups/b06e8bc419/summary **within the first 90 days of the disciplinary period**:

Righting a Wrong-Ethics and Professionalism in Nursing (3.0 hours)
Professional Accountability and Legal Liability for Nurses (5.4 hours)
Missouri Nursing Practice Act (2.0 hours)
Disciplinary Actions: What Every Nurse Should Know (4.8 hours)
Medication Errors: Detection and Prevention (6.9 hours)
Documentation: A Critical Aspect of Client Care (5.4 hours)

B. Licensee shall complete the following modules offered at Assessment Technologies Institute at https://www.atitesting.com/Home.aspx **within the first year of probation:**

- Medication Administration 1
- Medication Administration 2 (oral, ophthalmic, optic, nasal, inhalation, topical, vaginal, and rectal medication)
- Wound Care
- Infection Control

C. Specific information regarding these classes will be provided by the Discipline Administrator at Licensee's initial meeting with the Board.

D. Licensee shall submit proof of completion of these classes to the Board. A specific due date will be determined by the Board after the discipline goes into effect.

E. Failure to obtain the required contact hours by the due dates shall constitute a violation of the terms of discipline.

2. The State of Missouri is a member of the Nurse Licensure Compact. Pursuant to the Compact, while on probation with his/her home state, a licensee loses his/her multi-state privileges. Therefore, the Licensee may not work outside the State of Missouri pursuant to a multistate licensure privilege without written permission of the Missouri State Board of Nursing and the Board of Nursing in the party state where the Licensee wishes to work.

3. 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 25th DAY OF MARCH, 2013.

STATE BOARD OF NURSING

Lori Scheidt

Lori Scheidt
Executive Director

BEFORE THE STATE BOARD OF NURSING
STATE OF MISSOURI

STATE BOARD OF NURSING, Petitioner,	)	
vs.	)	Case Number 2011-001939
SANDRA RHODES, Respondent.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCIPLINARY ORDER

On November 9, 2012, the Administrative Hearing Commission issued a default decision against Respondent finding that the Board was entitled to the relief requested in its complaint and therefore finding cause to discipline the nursing license of Respondent for her various actions and inactions while working as an LPN at Timberlake Care Center.

Following a disciplinary hearing on March 7, 2013, the Board issued a Findings of Fact, Conclusions of Law and Disciplinary Order (Order) on March 25, 2013. Pursuant to that Order, Respondent's license was placed on probation for a period of two (2) years under specified terms and conditions.

On July 31, 2013, a complaint was filed alleging that Respondent had violated certain terms and conditions of the Order. The Board convened a hearing September 5, 2013, at 8:30 a.m., or as soon thereafter as the matter may be heard, at its regular meeting in Jefferson City to determine whether Respondent had violated the Order and what action, if any, the Board should take if Respondent had, in fact, violated the Order.

Respondent, though duly notified of the time and place of the hearing, failed to appear in person or by counsel. The Board was represented by Rodney Massman. Ian

Hauptli 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. Sandra Rhodes holds a license from this Board as a licensed practical nurse, 2009010471. Respondent's license was current and active at all times relevant herein.

3. Sandra Rhodes has failed to plead or otherwise defend against the action initiated upon a properly pled writing and upon proper notice by the Board that a probation violation hearing was scheduled against her on September 5, 2013, at 8:30 a.m. to determine the appropriate level of discipline, if any, to be assessed against the license of Sandra Rhodes for her violations of the Order. Respondent did contact Board staff and stated that she could not attend the hearing. She was offered a telephone hearing and instructed that she needed to submit a request with her telephone number in writing to participate in her hearing by telephone. She was informed that this could be done by e-mail. Respondent failed to submit anything in writing and failed to submit a telephone number where she could be contacted for her hearing.

4. Respondent was properly served with notice of the disciplinary hearing before the Board.

5. All allegations in the Complaint filed with the Board are deemed admitted by Respondent.

6. After the Administrative Hearing Commission issued a Default Decision on November 9, 2012, the Board held a disciplinary hearing on March 7, 2013, and thereafter issued its Findings of Fact, Conclusions of Law and Disciplinary Order (Order) on March 25, 2013 finding that discipline was appropriate as a result of Respondent failing to treat patient wounds, failing to administer medications and delaying care for patients but documenting that she had performed these tasks. Pursuant to that Order, Respondent's license was placed on probation for a period of two (2) years under specified terms and conditions.

7. In accordance with the terms of the Order, Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent was advised by certified mail to attend a meeting with the Board's representative on April 24, 2013 by telephone. Respondent did not attend the meeting or contact the Board to reschedule the meeting.

8. Pursuant to the terms of Respondent's probation in the Order, Respondent was to submit an employer evaluation from every employer quarterly, or, if Respondent was unemployed, a statement indicating the periods of unemployment.

9. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 25, 2013.

10. In accordance with the terms of the Order, Respondent was required to obtain continuing education hours covering the following categories: "Righting a Wrong–Ethics and Professionalism in Nursing"; "Professional Accountability and Legal

Liability for Nurses"; "Missouri Nursing Practice Act"; "Disciplinary Actions: What Every Nurse Should Know"; "Medication Errors: Detection and Prevention"; and "Documentation: A Critical Aspect of Client Care", and have the certificate of completion for all hours submitted to the Board by June 25, 2013.

11. The Board did not receive proof of completion of any of the required hours.

12. The Board considered the evidence presented at the hearing and determines that discipline is appropriate to be imposed against Respondent's nursing license.

13. The Board finds that this Disciplinary Order is issued to safeguard the public health.

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this proceeding, pursuant to the Order, §324.042 RSMo and §335.066.2 RSMo, to determine whether Respondent has violated terms of the Order.

2. Section 324.042 RSMo, provides:

> Any Board, commission, or committee within the division of professional registration may impose additional discipline when it finds after hearing that a licensee, registrant, or permittee has violated any disciplinary terms previously imposed or agreed to pursuant to a settlement. The board, commission, or committee may impose as additional discipline any discipline it would be authorized to impose in an initial disciplinary hearing.

3. Respondent violated the terms of discipline set forth in the Order as described in the Findings of Fact.

4. The Agreement, §324.042 RSMo and §335.066.2 RSMo allow the Board to take such disciplinary action that the Board deems appropriate for failure to comply with the terms of the Order.

5. "[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

Respondent's licensed practical nursing license was initially placed on probation as a result of documenting that she was treating patients' wounds when she actually was not doing so. She additionally documented that she was administering medications and/or tube feeding medications on several patients when she had not actually done so. This jeopardized patient care and recovery. As a result, the Board placed her license on probation with monitoring requirements to ensure that she was practicing safely, including meeting with the Board's discipline administrator to review the probationary terms, requiring employer evaluations to determine whether she was practicing safely, and requiring her to complete certain continuing education requirements. Respondent has taken no steps to even begin to comply with the terms and conditions placed upon her license.

Respondent failed to participate in her hearing and offered no mitigating evidence to the Board regarding the alleged probation violations or as to the appropriate

level of discipline the Board should impose. This Board cannot monitor whether she has made the improvements necessary to practice safely as a nurse since she is not performing any of the requirements imposed against her license. Nurses are required to read, follow and carry out physicians' orders for proper patient care. Respondent failed to do so, which is what initially caused her license to be placed on probation. She is now failing to follow the Board's requirements. This Board is persuaded by her actions, or inactions as the case may be, that Respondent cannot safely practice as a licensed practical nurse.

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 Sandra Rhodes is revocation in order to safeguard the health of the public.

DECISION AND ORDER

1. It is the decision of the Missouri State Board of Nursing that Respondent has violated the terms of the Order. Respondent's license is, therefore, subject to further disciplinary action.

2. The Missouri State Board of Nursing enters its Order and **REVOKES** the nursing license and the privilege to practice, if any, in the State of Missouri of Respondent, Sandra Rhodes, 2009010471. It is further ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Missouri pursuant to a multistate licensure privilege without the written permission of the State of Missouri and the Board of Nursing in the party state where Respondent wishes to practice nursing.

3. 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 11th DAY OF SEPTEMBER, 2013.

STATE BOARD OF NURSING

Lori Scheidt

Lori Scheidt
Executive Director