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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Registered Nurse License Number 766286	§	
issued to DOROTHY LATISHIA SANFORD	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boa considered the matter of DOROTHY LATISHIA SANFORD, Registered Nurse License Number 766286, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13) and 301.453, Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on September 24, 2013, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on 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 is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from San Antonio College, San Antonio, Texas, on December 14, 2008. Respondent was licensed to practice professional nursing in the State of Texas on March 3, 2009.

5. Respondent's nursing employment history includes:

5/2009- Present	Staff Nurse	Methodist Specialty and Transplant Hospital San Antonio, Texas

Respondent's nursing employment history continued:

5/2009-Unknown	Staff Nurse	Pyramed Home Health San Antonio, Texas
3/2010-Unknown	Staff Nurse	Hannah Home Health San Antonio, Texas
6/2010- 3/2013	Staff Nurse	Laurel Ridge Treatment Center San Antonio, Texas
4/2013-Present		Unknown

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, and has been in this position for nine (9) months.

7. On or about December 1, 2012, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to completely document on the discharge instructions that Patient Number 196855 should use two (2) puffs of an Albuterol inhaler every four (4) hours as needed for shortness of breath. Instead, Respondent documented only that it should be used as needed and did not include the number of puffs, hours, or that the dose was in micrograms. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the discharge instructions.

8. On or about December 1, 2012, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 198261 should take Seroquel 600 milligrams every night. Instead, Respondent incorrectly documented half the ordered dose. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

9. On or about February 4, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 198534 should take Desoxyn 5 milligrams three (3) tabs twice a day. Instead, Respondent incorrectly documented one-third of the ordered dose of medication. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

10. On or about February 5, 2013, while employed with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to completely and accurately document on the discharge instructions that Patient Number 198013 should take Abilify 5 milligrams one-half tablet every night, and Effexor XR 150 milligrams one (1) tab every morning. Instead, Respondent

documented double the ordered dose of Abilify and did not include Effexor ER in the instructions. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

11. On or about February 13, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 201153 should take Klonopin 0.5 milligrams every night, Keppra 500 milligrams twice a day, Synthroid 0.075 two (2) tabs and Cytomel 0.025 milligrams. Instead, Respondent documented the wrong frequency for Klonopin and Keppra and the wrong dose of Synthroid and Cytomel. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

12. On or about February 13, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 190577 should take Norco 10/325 two (2) tabs three times a day for pain. Instead, Respondent documented half the ordered dose. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

13. On or about February 13, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 205939 should take Depakote ER 500 milligrams three (3) tabs every night. Instead, Respondent documented one-third of the ordered dose. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

14. On or about February 18, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 206084 should take Seroquel 600 milligrams every night. Instead, Respondent documented twice the ordered dose. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

15. On or about February 18, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 194912 should take Depakote ER 500 milligrams every night. Instead, Respondent documented double the ordered dose. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

16. On or about February 18, 2013, while employed as a Staff Nurse with Laurel Ridge

Treatment Center, San Antonio, Texas, Respondent failed to completely document on the discharge instructions that Patient Number 203327 should use two (2) puffs of an Albuterol inhaler every four (4) hours as needed. Instead, Respondent documented only that the inhaler should be used every four (4) hours. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

17. On or about February 18, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 162163 should take Depakote ER 1000 milligrams every night, Trazodone 200 milligrams at night as needed for insomnia and Penicillin 500 milligrams, four (4) times a day for four (4) days. Instead, Respondent documented half the ordered dose of Depakote, half the ordered dose of Trazodone and did not include Penicillin in the instructions. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

18. On or about March 2, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions for Patient Number 200830 in that she documented Proventil two (2) puffs four (4) times daily as needed, which was not ordered. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

19. On or about March 2, 2013, while employed as a Staff Nurse with Laurel Ridge Treatment Center, San Antonio, Texas, Respondent failed to accurately document on the discharge instructions that Patient Number 206257 should take Wellbutrin 100 milligrams, one and a half tablets twice a day. Instead, Respondent documented that the patient should take one (1) tablet twice a day. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to a risk of harm from medication errors due to incorrect information on the hospital discharge instructions.

20. In response to the incidents in Findings of Fact Numbers Seven (7) through Nineteen (19), Respondent states that she followed protocol as she was trained to do and filled out the discharge instructions to the best of her knowledge. Respondent adds that when discharging a patient, she verbally informed that patient in laymen's terms of the correct usage, side effects and dosage of the medication.

21. Formal Charges were filed on August 27, 2013.

22. Formal Charges were mailed to Respondent on August 28, 2013.

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 to prove violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A)&(1)(D) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 766286, heretofore issued to DOROTHY LATISHIA SANFORD, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

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.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to

accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED.

PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(4) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(5) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(6) RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined

unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) year(s) of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT may be eligible for nurse licensure compact privileges, if any.

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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 is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 13 day of March, 20 14

Dorothy Sanford

DOROTHY LATISHIA SANFORD, RESPONDENT

Sworn to and subscribed before me this 13th day of March, 20 14.

SEAL

Rene McDonald

Notary Public in and for the State of Texas.

RENE McDONALD
NOTARY PUBLIC
State of Texas
Comm. Exp. 05-06-2017
NOTARY WITHOUT BOND

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 13th day of March, 2014, by DOROTHY LATISHIA SANFORD, Registered Nurse License Number 766286, and said Order is final.

Effective this 16th day of April, 2014.

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

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