BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 662229	§	
& Vocational Nurse License Number 159846	§	
issued to DONNA SUETTA OKELLEY	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of DONNA SUETTA OKELLEY, Registered Nurse License Number 662229, and Vocational Nurse License Number 159846, 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)(8),(10)&(13), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on December 3, 2020.

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 notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a vocational nurse in the State of Texas is in delinquent status. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from Vernon Regional Junior College, Vernon, Texas, on August 17, 1996. Respondent received an Associate Degree in Nursing from Vernon College, Vernon, Texas, on May 1, 1999. Respondent was licensed to practice vocational nursing in the State of Texas on October 2, 1996. Respondent was licensed to practice professional nursing in the State of Texas on July 13, 1999.

5. Respondent's nursing employment history includes:

10/96 – 1998	Unknown	
1999 – 2002	Nursing Supervisor	Texas Department of Corrections – Allred Unit Iowa Park, Texas
2002 – 2003	Staff RN Med-Surg/Ortho	United Regional Healthcare Wichita Falls, Texas
12/03 – 12/05	Staff RN Telemetry & PACU	Arlington Memorial Hospital Arlington, Texas
2004 – 2007	Agency RN	Crdentia Staffing Dallas, Texas
2007 – 2007	Hospice RN	Solaris Hospice Denton, Texas
07/07 – 09/07	Home Health RN	Accumed Home Health Denton, Texas
09/07 – 01/08	Home Health RN	Home Health Services of Denton Denton, Texas
02/08 – 05/11	Unknown	
06/11 – 06/16	RN	Brownfield Rehabilitation & Care Center Brownfield, Texas
04/16 – 06/16	RN – Inpatient Containment	GED Group (ICE) Laredo, Texas
06/16 – 07/16	Travel RN	Readylink Healthcare Thousand Palms, California
08/16 – 11/16	Unknown	
12/16 – 02/17	Travel RN	RN Network Staffing Boca Raton, FL
02/17 – 08/17	Travel RN	Nurses Pro Houston, Texas
09/17 – 11/17	Unknown	

Respondent's nursing employment history continued:

12/17 – Present	Travel RN	Genie Healthcare Monroe, New Jersey
09/19 – Present	Travel RN	Medical Solutions Omaha, Nebraska

6. On or about April 20, 2009, Respondent was issued the sanction of Remedial Education through an Order of the Board. On or about June 25, 2009, Respondent successfully completed the terms of the Order. A copy of the April 20, 2009, Order is attached and incorporated herein by reference as part of this Agreed Order.

7. At the time of the initial incident, Respondent was employed as a travel Registered Nurse (RN) with Medical Solutions, Omaha, Nebraska, and had been in that position for less than one (1) month.

8. On or about September 17, 2019, while utilizing a privilege to practice professional nursing from the State of Texas, and employed as a travel Registered Nurse (RN) with Medical Solutions, Omaha, Nebraska, and contracted with North Big Horn Hospital District - New Horizons Care Center, Lovell, Wyoming, Respondent documented that she administered Oxycodone 15mg to Resident Number NBH10000411 [SU] when the Oxycodone was not available in the facility at the time of the documented administration.

9. On or about September 18, 2019, while utilizing a privilege to practice professional nursing from the State of Texas, and employed as a travel Registered Nurse (RN) with Medical Solutions, Omaha, Nebraska, and contracted with North Big Horn Hospital District - New Horizons Care Center, Lovell, Wyoming, Respondent documented that she administered two (2) tablets of Norco 5/325mg to Resident Number NBH00003941 [HG] at 0548 but did not sign out the Norco on the Controlled Drug Administration Record.

10. On or about September 19, 2019, while utilizing a privilege to practice professional nursing from the State of Texas, and employed as a travel Registered Nurse (RN) with Medical Solutions, Omaha, Nebraska, and contracted with North Big Horn Hospital District - New Horizons Care Center, Lovell, Wyoming, Respondent failed to administer medications to Resident Number NBH00033370 [RR] when she was called to another patient's room and forgot to administer the medications. A later shift found some of the ordered medications missing from the patient's medication cup.

11. On or about October 19, 2019, while utilizing a privilege to practice professional nursing from the State of Texas, and employed as a travel Registered Nurse (RN) with Medical Solutions, Omaha, Nebraska, and contracted with North Big Horn Hospital District - New Horizons Care Center, Lovell, Wyoming, Respondent failed to administer eye drops, Buspar, Ropinirole, and Temazepam to Resident Number NBH00010024 [PM], as ordered

by the physician. Instead, Respondent left the medications in a cup on the resident's overbed table. Additionally, Responden documented that she administered the eyes drops, Buspar, Ropinirole, and Temazepam to Resident PM in the resident's medication administration record.

12. In response to Findings of Fact Numbers Eight (8) through Eleven (11), regarding Resident SU, Respondent states she did not administer the Oxycodone to the resident, but claims it was a typo and states that Cerner is not a user-friendly system and despite asking for help to correct the record, no one could assist her with any correction until the next day. Respondent states she asked for help and was shown how to correct her entry the following day. Regarding Resident RR, Respondent states she was not oriented on this hall, but accepted the assignment. Respondent states that at the end of med pass, she was supposed to administer Lasix, levothyroxine, and Norco to Resident RR, but the resident was still asleep, so his medications were in a soufflé cup awaiting him in the top drawer of the medication cart. Respondent states she was questioned about the Norco because she had spilled some pills earlier and had thrown them away. Respondent states the following day she rechecked the eMAR and confirmed she pulled the correct medications and states that the pill she discarded in the trash had nothing to do with this resident. Regarding Resident PM, Respondent states that the resident in the connecting room called out for help, so she placed the pills on the bedside table while the CNA was assisting Resident PM to her bed. Respondent states she went to help the other resident and admits she did not come back to administer the medications that were found on the bedside table by the oncoming shift. Regarding Resident DR, Respondent states the medication count was correct when she reported for her shift at 1800. Respondent states the following morning, the oncoming RN discovered that two Norco tablets were missing. Respondent add that she took a drug screen and it was negative; however, the off-going nurse was not given a drug screen. No harm came to any patients as a result of any actions in these allegations

13. The Wyoming Board of Nursing issued a Settlement Agreement, Stipulation, and Order of Reprimand to the Respondent on or about May 12, 2020, which required the Respondent to complete a course in Medication Errors: Causes and Prevention, which would have been a requirement of this Order, as well. A copy of the Settlement Agreement, Stipulation, and Order of Reprimand is attached hereto and incorporated herein for all purposes.

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)(B),(1)(C)&(1)(D) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(8),(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 662229, and Vocational Nurse License Number 159846, heretofore issued to DONNA SUETTA OKELLEY.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **REPRIMAND WITH STIPULATIONS** in accordance with the terms of this Order.

A. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Agreed Order.

III. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed

on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: *http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp*. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

IV. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that 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. Home study and video programs will not be approved.

B. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: 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. Home study courses and video programs will not be approved.

C. **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/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider.

Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse 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 period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Incident Reporting:** For the stipulation period, RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

D. **Nursing Performance Evaluations:** 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 individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for four (4) quarters [one (1) year] of employment as a nurse.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, 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 Order. 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 entry of this 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 Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. 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 possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 8 day of December, 2020

Donna Suetta O'Kelley
DONNA SUETTA OKELLEY, RESPONDENT

Sworn to and subscribed before me this 8 day of December 2020.

SEAL

ANGELIC ROSALINDA QUAID
Notary Public, State of Texas
Comm. Expires 02-20-2024
Notary ID 132367017

Angelic Quaid
Notary Public in and for the State of TEXAS

Approved as to form and substance.

_____
Joyce Stamp Lilly, Attorney for Respondent

Signed this _____ day of _____, 20____.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 8th day of December, 2020, by DONNA SUETTA OKELLEY, Registered Nurse License Number 662229, and Vocational Nurse License Number 159846, and said Agreed Order is final.

Effective this 21st day of January, 2021.

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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 662229 and	§	
Vocational Nurse License Number 159846	§	
issued to DONNA SUETTA O'KELLEY	§	ORDER

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

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of DONNA SUETTA O'KELLEY, Registered Nurse License Number 662229 and Vocational Nurse License Number 159846, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(13), Texas Occupations Code. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on February 12, 2009, by Katherine A. Thomas, MN, RN, Executive Director.

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.

2. Respondent waived 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. 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 Vernon Regional Junior College, Vernon, Texas, on August 17, 1996, and received an Associate Degree in Nursing from Vernon Regional Junior College, Vernon, Texas, in May 1999. Respondent was licensed to practice vocational nursing in the State of Texas on October 2, 1996, and was licensed to practice professional nursing in the State of Texas on July 13, 1999.

5. Respondent's nursing employment history includes:

1996 - 1998		Unknown
1999 - 2002	Nursing Supervisor	Texas Department of Corrections Allred Unit, Iowa Park, Texas
2002 - 2003	Staff Nurse Med/Surg & Ortho Units	United Regional Healthcare Wichita Falls, Texas
12/2003 - 12/2005	Staff Nurse Telemetry & PACU	Arlington Memorial Hospital Arlington, Texas
2004 - 2007	Agency Nurse	Crdentia Dallas, Texas
2007	Hospice Nurse	Solaris Hospice Denton, Texas
7/2007 - 9/2007	Home Health Nurse	Accumed Home Health Denton, Texas
9/2007 - 1/2008	Home Health Nurse	Home Health Services of Denton Denton, Texas
2/2008 - Present		Unknown

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with Arlington Memorial Hospital, Arlington, Texas, and has been in this position for one (1) year and five (5) months.

7. On or about May 29, 2005, while employed with Arlington Memorial Hospital, Arlington, Texas, Respondent failed to document her attempted communication with the physician and subsequent communication with the pharmacy regarding clarification of a physician's order to administer "Vitamin 2.5 mg this am." Respondent's conduct resulted in an incomplete medical record and was likely to injure the patient in that subsequent care givers would not have accurate information on which to base their care decisions.

8. On or about August 24, 2005, while employed with Arlington Memorial Hospital, Arlington, Texas, Respondent failed to administer K-dur to Patient Number M367010, as ordered by the physician, after she noted the order at 1635. The medication was subsequently administered by another nurse on the next shift. Respondent's conduct was likely to injure the patient from non-efficacious care.

9. On or about September 5, 2005, while employed with Arlington Memorial Hospital, Arlington, Texas, Respondent failed to note and implement a physician's order to apply Thromboembolic Deterrent (TED) hose for Patient Number M899911, written at 14:57 during her shift, as required. Respondent's conduct was likely to injure the patient from possible formation of peripheral blood clots.

10. On or about September 16, 2005, while employed with Arlington Memorial Hospital, Arlington, Texas, Respondent failed to note and implement a physician's order to administer Solumedrol 125 mg intravenously to Patient Number M666318, as required. Respondent's conduct was likely to injure the patient from non-efficacious care.

11. In response to the incidents in Findings of Fact Numbers Seven (7) through Ten (10), Respondent states the following:
    - Regarding clarification of the order to administer "Vitamin 2.5 mg," that she had called the physician to clarify the order but he had not called back before the pharmacy contacted her about the order. According to Respondent, the pharmacy technician stated that the pharmacy would contact the physician and send both the medication and a corrected order once the order had been clarified;
    - Regarding the K-dur, that she noted the order and initiated the procurement process from the pharmacy but she is unsure of the time frame before the medication was profiled in the system and was delivered by the pharmacy;
    - Regarding the TED hose, that the physician did not at any time insinuate the TED hose were an absolute necessity and that she placed the TED hose on the bedside table when they arrived at 17:00, asking the on-coming nurse for the next shift to apply them; and
    - Regarding the Solumedrol, that the order was somehow missed, possibly because the chart may have been placed back into the carousel or the chart may have remained with the physician, so the order was not noted and was not sent to the pharmacy.

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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 violations of Section 301.452(b)(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C), (1)(D)&(1)(M).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 662229 and Vocational Nurse License Number 159846, heretofore issued to DONNA SUETTA O'KELLEY, including revocation of Respondent's licenses to practice nursing in the State of Texas.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a Settlement agreement under Rule 408 of the Texas Rules of Evidence for purposes of civil or criminal litigation.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, 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 this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas 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) contact 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.state.tx.us/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. 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. The didactic portion of this course shall be a minimum of

six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor 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.state.tx.us/disciplinaryaction/stipscourses.html.*

(3) 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.state.tx.us/disciplinaryaction/stipscourses.html.*

(4) 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. *Information regarding this workshop may be found at the following web address: http://www.learningext.com/products/generalce/critical/ctabout.asp.*

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's licenses and RESPONDENT shall be eligible for multistate licensure 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 have reviewed this Order. I neither admit nor deny the violations 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 when this Order becomes final and the terms of this Order become effective, 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 licenses to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 13 day of April, 2009.

Donna Suetta O'Kelley

DONNA SUETTA O'KELLEY, Respondent

Sworn to and subscribed before me this 13 day of April, 2009.

SEAL

Malinda Kirkland

Notary Public in and for the State of Texas

MALINDA KIRKLAND
MY COMMISSION EXPIRES
November 17, 2009

Approved as to form and substance.

Kenda B. Dalrymple

Kenda B. Dalrymple, Attorney for Respondent

Signed this 15th day of April, 2009.

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 13th day of April, 2009, by DONNA SUETTA O'KELLEY, Registered Nurse License Number 662229 and Vocational Nurse License Number 159846, and said Order is final.

Effective this 20th day of April, 2009.

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

BEFORE THE WYOMING STATE BOARD OF NURSING

IN THE DISCIPLINARY MATTER OF	)	
DONNA O'KELLEY,	)	**Docket No. 201911036-SH**
REGISTERED PROFESSIONAL NURSE	)	
MULTISTATE LICENSURE PRIVILEGE.	)	

SETTLEMENT AGREEMENT, STIPULATION, AND ORDER OF REPRIMAND

The Disciplinary Committee, Susan Howard (PETITIONER), of the Wyoming State Board of Nursing (Board) and DONNA O'KELLEY, Registered Professional Nurse (RN) (RESPONDENT), pursuant to Wyoming Statute § 16-3-107(n) of the Wyoming Administrative Procedure Act (WAPA), Wyoming Statute § 33-21-122(c)(x) of the Wyoming Nurse Practice Act (NPA), and Chapter 8, Section 6 [Complaint Review and Investigation Process] of the Board's administrative rules, enter into this *Settlement Agreement, Stipulation, and Order of Reprimand* (Agreement), subject to approval by the Board.

FINDINGS OF FACT

1. RESPONDENT is licensed as a RN in Texas, and holds a Multi-State Licensure Privilege (MSP-RN) to practice nursing in Wyoming.

Factual Allegations

2. On November 22, 2019, the Board office received an administrative complaint against RESPONDENT alleging unsafe practice. The administrative complaint was assigned to PETITIONER for review, investigation, and recommendation (Docket No. 201911036).

3. Heidi Benson, Medical Solutions, filed the administrative complaint and alleged:

   a. RESPONDENT was working in Wyoming as a traveling nurse for Medical Solutions. RESPONDENT was assigned to work for North Big Horn Hospital and New Horizons Care Center in Lovell, Wyoming.

   b. On November 7, 2019, Medical Solutions was contacted by North Big Horn Hospital regarding canceling RESPONDENT's contract due to multiple drug administration discrepancies.

   c. On November 8, 2019, RESPONDENT denied any drug diversion to her recruiter and she submitted to drug testing.

   d. On November 12, 2019, RESPONDENT's drug screen results were returned as negative.

e. RESPONDENT was subsequently terminated from Medical Solutions after North Big Horn Hospital cancelled her contract.

4. According to the facility documentation,

a. On September 17, 2019, at 2239, RESPONDENT documented she administered Oxycodone 15mg to a patient.

i. The medication was signed out in the computer, not signed out in the "narc book," and the medication was not available in the building at the time.

ii. RESPONDENT stated she documented it was given, but she was not aware of how to show "not given" when made aware the medication was not available.

b. On September 18, 2019 at 0548, RESPONDENT documented that she administered Norco 5/325mg to a patient.

i. The medication was signed out in the computer, but the medication was not signed out in the "narc book," and the count was correct.

ii. RESPONDENT said she could not recall this or what could have gone wrong.

c. On September 19, 2019, RESPONDENT did not administer medication to a patient. Coleen Peregoy, LPN, provided a statement explaining:

i. RESPONDENT stated she could not wake up the patient at 0500, so RESPONDENT placed his medications in a cup in the top drawer of the cart.

ii. She inspected the medications and noted not all the pills were in the cup.

1. Only one (1) 80mg Lasix, which should have been 120mg of Lasix;

2. There was a Gabapentin, which is a 0800 medication; and

3. Missing was a 0600 Levothyroxine.

iii. She looked in the "narc book" and discovered RESPONDENT signed out Norco, but Norco was not in the cup. She told RESPONDENT not all medications were in the cup.

iv. RESPONDENT explained Cindy, the other nurse, and a student nurse, were also present in the medication room when RESPONDENT stated RESPONDENT thought it was the other pill RESPONDENT dropped and not the Norco, but it was the Norco. Cindy showed RESPONDENT how to un-chart.

v. She asked RESPONDENT where RESPONDENT dropped the Norco. RESPONDENT stated RESPONDENT dropped it in the medication room on the floor and threw it away. She asked where RESPONDENT threw it away, in a drug box or needle box. RESPONDENT stated the needle box.

vi. RESPONDENT explained Cindy then proceeded to tell RESPONDENT another nurse must watch RESPONDENT waste it and sign for it. She also showed RESPONDENT where in the "narc book" to write wasted medications.

vii. She notified Supervisor Jason Tippetts of the situation. They emptied both needle boxes from both carts, but Norco was not found.

viii. These findings were reported to Traci Harrison, RN, Asst. DON.

d. According to a *Medication Error Report* filed against RESPONDENT, on October 18, 2019, RESPONDENT did not administer a medication to a resident because she could not find the bottle in the cupboard.

e. According to a *Medication Error Report* filed against RESPONDENT, on October 19, 2019, RESPONDENT left medication in the resident room on a table.

f. On November 7, 2019 at 0700, RESPONDENT experienced a pill count discrepancy. Vicki Croft, RN, provided a statement explaining:

i. She was taking over on pod 2 from RESPONDENT. The narcotics count on the pod 2 cart was correct until RESPONDENT reached D.R.'s card for Norco 5/325. The sign out sheet said there were 48 tablets left; the card actually contained 46 Norco tablets, making the count short 2 tablets.

ii. RESPONDENT said the count was on when RESPONDENT took over from Cassi Colvin, LPN, from the day shift.

iii. She investigated the missing two (2) tablets of Norco and talked to the nurses, who worked the floor on pod 2 the previous two (2) days. All nurses reported the count was on when they had taken over the floor on pod 2.

iv. A further inspection of all medication cards was completed with no other medication errors.

v. She notified Michelle Horrocks, RN, DON.

5. RESPONDENT responded to the administrative complaint and explained:

a. On September 17, 2019, she documented she gave an Oxycodone to S.U., but she had not. It was a typo in the IT system, Cerner. She stated Cerner software is not

user-friendly software, and even the regular staff had issues with documentation. She did not know how to back the entry out of the system.

b. On September 19, 2019, LPN Peregoy was unpleasant and rude to her. LPN Peregoy kept repeating she was to give a Norco, Gabapentin tablet (not capsule), Furosemide, and Levothyroxine. The confusion started when LPN Peregoy repeatedly stated she had given a Gabapentin instead of Norco. When she returned to the facility on September 21, she rechecked the E-MAR and discovered she had pulled the correct medications: Norco, Furosemide, and Levothyroxine; and subsequently LPN Peregoy had given the patient the correct medications. Gabapentin was not scheduled during her shift, it was ordered for 0900. The pill she discarded earlier in the evening had nothing to do with this patient in any way. The resident received the correct medications.

c. On October 18, 2019, she documented she pulled Zyprexa 10mg. She looked for the medication, but were unable to locate it and specified this on the E-MAR. She later learned the facility had a "cupboard" area assigned for medication brought to the facility by family. She was never told about the "cupboard" during orientation, therefore she was unable to locate and administer the medication.

d. On October 19, 2019, she was notified of medications left on the bedside table of a resident during her shift: eye drops, Buspar, Ropinirole, and Temazepam. She got involved with the resident in the connecting room and did not return to administer the meds that were found on the bedside table during the next shift. These meds were found to be accurate and not stolen, misplaced, or taken by her. She did make the error in forgetting to go back and give the medication and she took responsibility for that, but no harm came to the patient as a result.

e. On November 6, 2019, she counted medications with LPN Calvin. LPN Calvin had the narcotic book and she had the blister packs. The count was correct according to LPN Calvin, who said her count of the blister packs matched the book. The next morning, RN Croft found two Norco 5/325 missing. She believed the count was wrong when she took it from LPN Calvin, but LPN Calvin had the book and she did not.

f. She submitted to a drug test after this incident, which was negative. However, to her knowledge, LPN Calvin was not required to take a drug test.

Grounds for Disciplinary Action

6. PETITIONER alleges RESPONDENT's conduct in Paragraphs 2 through 5, if established by clear and convincing evidence at a contested case hearing, constitutes violations of the NPA, specifically Wyoming Statute § 33-21-146(a)(iv)(B)[unsafe nursing practice].

7. PETITIONER further alleges RESPONDENT's conduct in Paragraphs 2 through 5, if established by clear and convincing evidence at a contested case hearing, constitutes

violations of the Board's rules, Chapter 8, Section 3 [Grounds for Discipline], specifically Chap. 8, Sec. 3(a)(x)[performed unsafe client care].

PETITIONER's Recommendation for Reprimand

8. **Authority for Discipline.** Pursuant to NPA, the Board may "determine and administer appropriate disciplinary action against all individuals found guilty of violating this act and board rules and regulations." Wyo. Stat. Ann. § 33-21-122(c)(x).

9. **Authority for Recommendation of Approval of Settlement Agreement.** Pursuant to Chapter 8, Section 6(c)(iii) of the Board's rules, PETITIONER may recommend "[a]pproval of a settlement agreement, which may include a reprimand, conditions, restrictions, non-renewal, suspension, voluntary surrender, other discipline or a combination thereof[.]" Additionally, pursuant to the WAPA, "informal disposition may be made of any contested case by stipulation, agreed settlement, consent order or default." Wyo. Stat. Ann. § 16-3-107(n).

10. **Recommendation for Stayed Reprimand.** A violation of the statutory and rule provisions identified in Paragraphs 6 and 7 is grounds for disciplining RESPONDENT's MSP-RN. PETITIONER has determined a reprimand is an appropriate resolution of the administrative complaint in lieu of initiating a formal disciplinary proceeding against RESPONDENT. Additionally, PETITIONER has determined and recommends the reprimand should be stayed if RESPONDENT complies with the following terms:

    a. Within **ninety (90) days** of the effective date of this Agreement, RESPONDENT shall complete the required educational courses or training, and provide documentation of completion to PETITIONER. RESPONDENT shall complete the following educational courses or similar courses as otherwise approved by the PETITIONER:

        i. **Medication Errors: Causes & Prevention -** https://www.ncsbn.org/5132.htm.

    b. If RESPONDENT fails to provide necessary documentation of completion of the coursework, as provided above, the stay will automatically be lifted and RESPONDENT's **MSP-RN** shall be reprimanded.

RESPONDENT's Representations Regarding this Agreement

11. RESPONDENT represents she has read this Agreement in its entirety, has had an opportunity to consult with counsel, fully understands the contents and requirements herein, and agrees to abide by the Order set forth herein *in lieu* of a contested case hearing.

12. By executing this Agreement, RESPONDENT waives her right to any applicable administrative contested case hearing or appeals in this matter pursuant to the WAPA [Wyoming Statute §§ 16-3-107 through -115], the NPA, the Board's rules, or any other applicable law or constitutional right.

13. Due and proper notice of this matter has been afforded to RESPONDENT, and RESPONDENT agrees she has not been subjected to undue influence, pressure, or coercion by PETITIONER, the Board, its staff, or the Office of the Attorney General, and she is entering into this Agreement under her own free will after having the opportunity to obtain advice from an attorney regarding the consequences of entering into this Agreement.

14. RESPONDENT understands this Agreement shall be submitted to the Board, which may either approve or reject the Agreement. Should the Board reject the Agreement, RESPONDENT shall have an opportunity to request a contested case hearing in accordance with the WAPA, the NPA, and the Board's rules. If the Board does not approve this Agreement and a contested case hearing takes place as a consequence, RESPONDENT further represents and agrees she does not object to the Board's hearing the case on the basis the Board has become disqualified due to its review and consideration of this Agreement and its contents.

15. RESPONDENT understands this Agreement shall become a permanent part of her record with the Board.

16. RESPONDENT understands this Agreement constitutes a public record within the meaning of the Wyoming Public Records Act [Wyoming Statute §§ 16-4-201 through -205], and, upon proper request, shall be subject to disclosure, inspection, and dissemination in accordance with or except as otherwise provided by applicable federal and state laws.

17. RESPONDENT understands that if RESPONDENT violates this Agreement and the stay is lifted, this Agreement shall constitute disciplinary action of the Board and will be reported in accordance with applicable federal and state law and shall be subject to publication on the Board's website.

CONCLUSIONS OF LAW

18. Paragraphs 1 through 17 of the Findings of Fact are incorporated herein by reference.

Jurisdiction

19. The Board is the sole, exclusive, and duly-authorized licensing, regulatory, and administrative agency in the State of Wyoming regarding the practice of nursing as authorized by the NPA, Wyoming Statute §§ 33-21-119 through -157.

20. Pursuant to the NPA, the Board has authority to "determine and administer appropriate disciplinary action against all individuals found guilty of violating this act and board rules and regulations. The board retains jurisdiction over the person issued a license, certificate or temporary permit pursuant to this act, regardless of whether the license, certificate or permit expired, lapsed or was relinquished during or after the alleged occurrence of conduct proscribed by this act." Wyo. Stat. Ann. § 33-21-122(c)(x).

21. RESPONDENT is licensed as a RN in Texas, and holds a MSP-RN to practice nursing in Wyoming.

22. The Board has jurisdiction in this matter and over RESPONDENT.

Disciplinary Authority

23. Pursuant to Chapter 8, Section 16(a)(i) of the Board's rules, the Board may resolve an administrative complaint by approving the recommendations of PETITIONER.

24. Pursuant to the WAPA, "informal disposition may be made of any contested case by stipulation, agreed settlement, consent order or default." Wyo. Stat. Ann. § 16-3-107(n).

Grounds for Disciplinary Action

25. The NPA identifies grounds for disciplining licensees upon proof a RN:

> (iv) Is unfit or incompetent to practice nursing by reason of negligence, habits or other causes including but not limited to:
>
> * * *
>
> (B) Performance of unsafe nursing practice or failure to conform to the essential standards of acceptable and prevailing nursing practice, in which case actual injury need not be established.

Wyo. Stat. Ann. § 33-21-146(a)(iv)(B).

26. The Board's rules also identify grounds for disciplining licensees upon proof a RN "[h]as performed unsafe client care[.]" *Bd. of Nursing Rules,* Ch. 8, Section 3(a)(x), 054.0002.8.11192018.

Conclusions

27. The Board concludes RESPONDENT's conduct as set forth in Paragraphs 2 through 5, if established by clear and convincing evidence at a contested case hearing, constitutes violations of the NPA, specifically Wyoming Statute § 33-21-146(a)(iv)(B).

28. The Board concludes RESPONDENT's conduct as set forth in Paragraphs 2 through 5, if established by clear and convincing evidence at a contested case hearing, constitutes violations of the Board's rules, specifically Chapter 8, Section 3(a)(x).

29. The Board concludes the violations of the statutory and rule provisions identified are grounds for disciplining RESPONDENT. Based on PETITIONER's recommendation, the Board concludes reprimanding RESPONDENT's MSP-RN is appropriate. The Board concludes that reprimand should be stayed as long as RESPONDENT complies with the terms identified in Paragraph 10, above.

[CONTINUED ON FOLLOWING PAGE]

ORDER OF REPRIMAND

IT IS THEREFORE HEREBY STIPULATED AND ORDERED AS FOLLOWS:

1. **Board Approval of Agreement.** The Board approves this Agreement for the conduct set forth in the Findings of Fact and Conclusions of Law in this Agreement.

2. **Stayed Reprimand.** RESPONDENT's MSP-RN shall be **REPRIMANDED**; however, such reprimand shall be immediately **STAYED** and remain stayed provided RESPONDENT remains fully compliant with this Agreement.

3. **Automatic Lifting of the Stay.** If RESPONDENT fails to comply with this Agreement, the **stay shall be automatically lifted** and RESPONDENT's **MSP-RN** shall be **reprimanded**, resulting in a disciplinary action.

4. **Required Educational Courses and Training.** RESPONDENT shall complete educational courses and training described in this paragraph, and provide PETITIONER with proof of completion within **ninety (90) days** of the effective date of this Agreement:

   a. **Medication Errors: Causes & Prevention** - https://www.ncsbn.org/5132.htm.

5. **Publication of Discipline.** If RESPONDENT violates this Agreement and the stay is lifted, this Agreement shall be subject to publication on the Board's website.

6. **Reporting by Board of Discipline.** If RESPONDENT violates this Agreement and the stay is lifted, this Agreement will constitute authorized disciplinary action of the Board and, as such, shall be reported in accordance with applicable federal and state law.

7. **Public Record of the Board.** This Agreement shall become a part of RESPONDENT's permanent record with the Board. This Agreement, as well as the information that is part of Docket No. 201911036, constitutes public records within the meaning of the Wyoming Public Records Act [Wyoming Statute §§ 16-4-201 through -205], and, upon proper request, shall be available for inspection and dissemination in accordance with applicable federal and state law.

8. **Continuing Jurisdiction.** The Board shall retain continuing jurisdiction in this matter to take further action as may be necessary to conclude this matter or other actions permitted by law.

9. **Waiver of Contested Case Hearing.** RESPONDENT's execution of this Agreement includes her full waiver of any contested case hearing or appeal to which she may be entitled to pursuant to the WAPA, the NPA, the Board's rules, or any other applicable law or constitutional right.

10. **Effective Date.** This Agreement shall become effective upon full and complete execution by all signatories below. This Agreement may be executed in any number of counterparts and by different parties in separate counterparts. Each counterpart when so executed shall

be deemed to be an original and all of which together shall constitute one and the same agreement. Signatures, originally signed by hand, but transmitted via e-mail or fax, shall also be deemed valid and binding original signatures.

11. **Enforcement.** This Agreement shall be enforceable in the Laramie County District Court in and for the State of Wyoming according to the laws of the State of Wyoming.

12. **Entire Agreement.** This Agreement constitutes the full and entire understanding between the parties RESPONDENT, PETITIONER, and the Board. RESPONDENT's execution of this Agreement includes her representation and acknowledgement she has read and understands the terms and conditions of this Agreement, has been given an opportunity to consult and/or has consulted with counsel of her choice, and accordingly voluntarily enters into this Agreement of her own choosing and shall be bound by the terms and conditions thereof, until the Board issues any order to the contrary. RESPONDENT has been given no additional inducement to enter into and execute this Agreement. Should any portion of this Agreement be judicially determined to be void, illegal or unenforceable, the remainder of the Agreement shall continue in full force and effect, and either party may renegotiate the terms affected by the severance.

[SIGNATURES APPEAR ON FOLLOWING PAGE]

AGREED TO AND ACCEPTED BY RESPONDENT:

I, DONNA O'KELLEY, RESPONDENT herein, swear I have read the foregoing Agreement and agree to its terms and conditions as provided above.

Donna O'Kelley — Date: 4-20-20

STATE OF Nebraska)
) SS
COUNTY OF Douglas)

The foregoing document was subscribed and sworn to before me by Donna O'Kelley, personally known to me or having established her identity by means of sufficient documentation, purporting to be the person signing the document, and the signature on the foregoing document was made in my presence, on the 20 day of April, 2020.

My Commission Expires: 02/21/2023

Notary Public

GENERAL NOTARY - State of Nebraska
ANEESH BHATTARAI
My Comm. Exp. February 21, 2023

[ADDITIONAL SIGNATURES ON FOLLOWING PAGE]

AGREED TO AND ACCEPTED BY PETITIONER, DISCIPLINARY COMMITTEE:

Susan M. Howard MSN RN-BC

Susan Howard, MSN, RN-BC

April 20, 2020

Date

APPROVED AS TO FORM:

Jessica Frint
Senior Assistant Attorney General
Attorney for PETITIONER

5/4/20

Date

APPROVED BY AND FOR THE WYOMING STATE BOARD OF NURSING:

Marjory Chen MSN

President or President's Designee

05.12.2020

Date