

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Vocational Nurse §
License Number 81739 and Registered §
Nurse License Number 461935 §
issued to Aleyamma George Thomas §



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.
Aleyamma George Thomas
Executive Director of the Board

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 461935 and Vocational Nurse License Number 81739, issued to Aleyamma George Thomas, 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.

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

FINDINGS OF FACT

1. Respondent's license to practice vocational nursing in the State of Texas is currently in delinquent status. Respondent's license to practice professional nursing in the State of Texas is in current status.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing.
3. Respondent received a Diploma in Vocational Nursing from J.J. Group of Hospitals, Bombay, India on February 28, 1969. Respondent was licensed to practice vocational nursing in the State of Texas on October 18, 1979. Respondent received a Diploma in Registered Nursing from J.J. Group of Hospitals, Bombay, India on February 28, 1969. Respondent was licensed to practice professional nursing in the State of Texas on January 25, 1982.
4. Respondent's complete nursing employment history is unknown.

5. On or about February 18, 2011, the Texas Board of Nursing notified Respondent of the following allegations:

- On or about June 20, 1997, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of two (2) years.
- On or about June 4, 2003, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of one (1) year.
- On or about February 23, 2005, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that reinstated her license to practice nursing in the State of Washington.
- On or about February 3, 2009, Respondent submitted her Registered Nurse Online Renewal Document to the Texas Board of Nursing in which she provided false, deceptive and/or misleading information, in that she answered "No" to the question:

"Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation..."

Specifically, on or about June 20, 1997, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of two (2) years. On or about June 4, 2003, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of one (1) year.

- On or about February 17, 2011, Respondent submitted her Registered Nurse Online Renewal Document to the Texas Board of Nursing in which she provided false, deceptive and/or misleading information, in that she answered "No" to the question:

"Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation..."

Specifically, on or about June 20, 1997, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her

license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of two (2) years. On or about June 4, 2003, Respondent was issued an Order by the State of Washington, Department of Health, Olympia, Washington, that suspended her license to practice nursing in the State of Washington until successful completion of a refresher course, then her license would be probated for a period of one (1) year.

6. On April 21, 2011, the Board received a notarized statement from Respondent voluntarily surrendering the right to practice nursing in Texas. A copy of Respondent's notarized statement, dated April 18, 2011, is attached and incorporated herein by reference as part of this Order.

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)(2),(8)&(10), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.12(1)(B),(6)(H)&(I).
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, the Board may impose conditions for reinstatement of licensure.
6. Any subsequent reinstatement of this license will be controlled by Section 301.452 (b), Texas Occupations Code, and 22 TAC §§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 461935 and Vocational Nurse License Number 81739, heretofore issued to Aleyamma George Thomas, to practice professional and vocational nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional or vocational nursing, use the title of registered nurse or vocational nurse or the abbreviations RN or LVN or wear any insignia identifying herself as a registered or vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered or 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 professional or vocational nursing in the State of Texas.

Effective this 25 day of April, 2011.



TEXAS BOARD OF NURSING

Katherine A. Thomas

By: _____

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

Aleyamma George Thomas
26 73rd Street Southwest
Everett, Washington 98203
Texas LVN License #81739
and
Texas RN License # 461935

Voluntary Surrender Statement

April 12, 2011

Dear Texas Board of Nursing:

I no longer desire to be licensed as a professional or vocational nurse. Accordingly, I voluntarily surrender my license/licenses to practice in Texas. I waive representation by counsel and consent to the entry of an Order which outlines requirements for reinstatement of my license. I understand that I will be required to comply with the Board's Rules and Regulations in effect at the time I submit any petition for reinstatement.

Signature *Aleyamma*

Date 4/18/2011

Texas Nursing License Number/s RN# 461935, LVN# 81739

The State of Texas

Before me, the undersigned authority, on this date personally appeared Aleyamma George Thomas who, being duly sworn by me, stated that she executed the above for the purpose therein contained and that she understood same.

Sworn to before me the 18th day of April, 2011.

SEAL BONNIE MELLICK
NOTARY PUBLIC
STATE OF WASHINGTON
MY COMMISSION EXPIRES
03-30-13

Bonnie Mellick
Notary Public in and for the State of Washington

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION**

In the Matter of the License to Practice)	
as a Registered Nurse of:)	OPS No. 96-10-10-530 RN
	Prog. No. RN 1156
ALEYAMMA THOMAS, R.N.,)	
	FINDINGS OF FACT,
Respondent.)	CONCLUSIONS OF LAW,
_____)	AND ORDER

A hearing was held before the Washington State Nursing Care Quality Assurance Commission (Commission), and Zimmie Caner, Presiding Officer for the Commission, on May 19 and 20, 1997, at the Wyndham Garden Hotel, SeaTac, Washington. Kelley Larsen, Assistant Attorney General, represented the Department of Health (Department). The Respondent, Aleyamma Thomas, R.N., was present but was not represented by counsel. The Commission members hearing this case were Becky Kerben, L.P.N., Edwina Dorsey, R.N., Ellen Rosbach, R.N., and Lorraine Overmyer. The Commission, having heard the testimony and considered the evidence and the argument of the parties, now issues the following:

I. PROCEDURAL HISTORY

1.1 On September 13, 1996, the Commission issued a Statement of Charges (Charges) alleging unprofessional conduct. On September 23, 1996, the Respondent filed her answer denying the charges.

1.2 On December 2, 1996, Health Law Judge Stockman issued Prehearing Order No. 1 that granted the Respondent's motion to continue the prehearing conference.

1.3 On April 15, 1997, Judge Stockman issued Prehearing Order No. 2 that listed the parties' witnesses and exhibits which were disclosed and uncontested during the prehearing conference.

1.4 On May 12, 1997, a telephonic prehearing conference was held before Judge Stockman, during which the Respondent requested aid in persuading witnesses to appear at the hearing on her behalf. Judge Stockman issued subpoenas addressed to the Respondent's witnesses, but informed the Respondent that it was her responsibility to serve and/or mail the subpoenas.

1.5 During the hearing on May 19 and 20, 1997, Laurie Masters, R.N.; Penny Parks, R.N.; Emily Carter, R.N.; Randy DeJong, R.N.; Doris VanDeCastelee, R.N., D.N.S.; Patricia Kimes, L.P.N.; Charlotte Kellie, R.N.; Wendy Jackson, R.N.; Tresita Morales, R.N.; and the Respondent testified. Fifty-three (53) exhibits were admitted with no objections. These exhibits include medical records and complaints related to the twenty-three patients encompassed in the Statement of Charges, protocol/policy documents and the Respondent's employee records from Providence General Medical Center (Providence) and from Merry Haven Health Care Center (Merry Haven).

II. FINDINGS OF FACT

2.1 The Respondent, Aleyamma Thomas, R.N., is a registered nurse licensed to practice in the state of Washington and was so licensed at all times material hereto.

2.2 From October 5, 1995 through December 6, 1995, while employed at Merry Haven in Everett, Washington, the Respondent failed to practice nursing safely or in accordance with generally accepted standards of practice of nursing, as demonstrated by paragraphs 2.3, 2.4, 2.5, 2.6, 2.8 and 2.9.

2.3 On November 17, 1995, the Respondent failed to remain with Patient A until her medication was swallowed. The testimony of Doris VanDeCastelee, R.N., and

Exhibit 2 support this finding. Ms. VanDeCastele, the Assistant Director of Nursing at Merry Haven, supervised the Respondent. On November 17th, Cordelia Burch, L.P.N., reported to Ms. VanDeCastele and documented that Patient A had not taken her medication because the Respondent did not explain why she was giving the medication to Patient A. Once Ms. Burch explained the purpose of the medication, Patient A took the medication. Page two of Exhibit 2. The Respondent denied this allegation, but also testified that she had to administer medications to 45 patients; that she did what she could in the time allotted; and that her coworkers expected her to do their work. The Commission finds Ms. VanDeCastele's testimony, Ms. Burch's written statement and Exhibit 2 consistent, logical, and therefore credible. The Commission finds the Respondent's denial and explanations inconsistent, and therefore not credible.

2.4 On November 17, 18, 19, and 20, 1995, the Respondent failed to administer a 50 mg capsule of elemental Zinc to Patient B, and made incorrect entries in Patient B's medication record, page four of Exhibit 4. Insufficient evidence was presented to prove that the Respondent intended to make false entries. The Respondent testified that she administered the 50 mg capsule of elemental Zinc, but later testified that she had signed the medication error report. On the report, page one of Exhibit 3, the Respondent admitted the error and wrote that she would avoid this medication error from happening again by "checking the medication dosage properly." Ms. VanDeCastele testified that Patient B was to be administered two Zinc capsules, one 30 mg and one 50 mg, and the Respondent only administered the 30 mg capsule on the four days in question. The Respondent documented on the Medication Record that she administered a 50 mg tablet and a 30 mg tablet of elemental Zinc on November 17, 18, 19 and 20, 1995, although the 50 mg tablet was not administered.

2.5 On November 20, 1995, the Respondent failed to administer Baclofen to Patient C and made an incorrect entry in Patient C's Medication Record, page three of

Exhibit 7. The Respondent admitted this error in the Medication Error Report, and wrote that she would check the medication sheet properly to avoid this error again. The Respondent denied this omission in her testimony, but admitted that she signed the Medication Error Report, page one of Exhibit 6. Insufficient evidence was presented to support the allegation that the Respondent intentionally made a false entry.

2.6 On or about November 19, 1995, the Respondent administered Carafate and Iron at the same time to Patient D. As a result, Patient D complained of nausea and threw up an emesis with a red color consistent with the red coating on the iron tablets, not the red color from red food such as jello, as the Respondent claimed. Patricia Kimes, L.P.N., testified that she saw Patient D throw up, and that the patient had not eaten lunch nor did the Respondent provide food prior to the administration of the medications. Charlotte Kellie, R.N., testified that on November 19, 1995, the Respondent admitted that she administered these medications together because it takes too much time to administer the medications separately. The Respondent also stated to Ms. Kellie that she does not see "why I have to give these medicines at all different times." Page two of Exhibit 14. The Respondent's denial is not credible in light of the consistent testimony of two other floor nurses, the Respondent's admission to Ms. Kellie and Exhibit 14 documentation of the event the day it occurred.

2.7 Insufficient evidence was presented to support the allegation that between November 23-26, 1995, the Respondent failed to administer two doses of Lasix to Patient A and made false entries in the medication record. The Medication Error Report only addresses November 25 and 26, 1995, and on the report the Respondent states that she administered Lasix on November 25, 1995, and the remainder of the Respondent's portion of the report is illegible. The only other document that was presented is a copy of the Lasix "blister package." This provides no answer, because it is not clear whether any Lasix tablets were removed on the days in question. The

nurses initials are illegible, and it is not clear what day each initial relates to on the blister package.

2.8 On November 26, 1995, the Respondent failed to administer a Zinc 30 mg capsule to Patient B, and made an incorrect entry on the Medication Record, page two of Exhibit 11. Insufficient evidence was presented to prove that the Respondent intended to make a false entry. The Respondent denied the failure to administer Zinc 30 mg in her testimony, but admitted that she signed the Medication Error Report, page one of Exhibit 10. The Respondent wrote in the Medication Error Report that she will prevent this error from happening again by "checking the medication cards and the MAR." The Respondent never explained the inconsistency between her written admission in Exhibit 10 and her subsequent denial. As a result, her testimony was not credible.

2.9 On December 2, 1995, the Respondent administered Lasix to Patient E on an improper day and contrary to physician orders. The Lasix was to be administered every other day. The Respondent admitted to this error in her testimony, and the Department presented supporting evidence in Ms. VanDeCastele's testimony and Exhibit 12.

2.10 From October 1990 through May 23, 1995, while employed at Providence in Everett, Washington, the Respondent repeatedly failed to practice nursing safely or in accordance with generally accepted standards of practice of care, as demonstrated by the findings in paragraphs 2.12 through 2.18, 2.20, 2.21, 2.22, 2.24, 2.25, 2.28 through 2.31. During the Respondent's employment at Providence, the Respondent received regular counseling from her supervisors, Laurie Masters, R.N., Nurse Manager; Penny Parks, R.N., Assistant Director/Charge Nurse, to help her improve her nursing skills and communication skills, and to address the issues raised by patient and staff complaints. During this four and one-half years, the Respondent would have

periods of improvement only to later slip back into a problematic period, until her employment ended at Providence.

2.11 On or about February 16, 1994, the Respondent left Patient F on a bedpan for approximately twenty minutes pursuant to the patient's request. This is not below the standard of nursing care. The Respondent admitted to this fact and explained in her testimony that the patient requested to remain on the bedpan because she needed more time to relieve herself.

2.12 On February 16, 1994, the Respondent with the help of a male nurses' aid held Patient F down to administer Demerol, a pain medication, by injection. The patient had not requested the medication, and the Demerol had been taken orally prior to this occasion. As a result the patient became very upset. The testimony of Penny Parks, R.N., and Emily Carter, R.N., pages 5-6 of Exhibit 17 and Exhibit 18 support this allegation. The Respondent testified that the patient was confused and refused the Demerol. Ms. Carter testified that the patient was credible in her complaint against the Respondent, because the patient was oriented and clear about what she wanted and clear in her description of what had occurred. The Respondent did not have good cause to use force in administering the Demerol by injection. This treatment of Patient F was below the standard of care.

2.13 On or about February 16, 1994, the Respondent refused to help Patient G after the patient had a bowel movement that soiled the patient and her bed. The patient had requested help because she could not reach that area of her body. Patient G completed and signed a Patient Experience Survey, page four of Exhibit 20. Patient G wrote that the Respondent refused to help after a bowel movement resulting in feces soiling the patient and her bed. Ms. Masters testified that she counseled the Respondent on this patient complaint, and page five of Exhibit 17 contains her counseling notes regarding Patient G. The Respondent's denial of the patient's

complaint and of Ms. Masters' counseling is not credible in light of the clear statement written by Patient G, Ms. Masters' testimony and the counseling records.

2.14 On March 5, 1994, the Respondent left Patient H on a bedpan despite the patient's request and ability to use a bedside commode. Urine spilled on the sheets and the patient requested clean sheets. The Respondent refused to change Patient H's linens after they became soiled. The patient remained in these sheets for three hours until Candace Wheedon, R.N., relieved the Respondent. At the request of Patient H, Ms. Wheedon helped Patient H write a complaint. Page one of Exhibit 21 is the complaint that Patient H read and signed on March 5, 1994. The Respondent's denial is not credible in light of Patient H's clear, detailed complaint that was made the day she received poor treatment from the Respondent.

2.15 On March 10, 1994, the Respondent failed to explain the use of a patient controlled anesthesia (PCA) pump and was abrupt to Patient I, following her surgery. The Respondent told Patient I not to push the button so many times. This instruction was incorrect. As a result, the patient did not self administer enough pain medication, and suffered from pain unnecessarily. Patient I did not push her call button for help because the Respondent was abrupt and treated her as an inconvenience and a bother. The testimony of Laurie Masters, R.N., and page four of Exhibit 23, a Patient Feedback Memo, support this allegation. The Respondent testified and stated to Ms. Masters at the time of the complaint that it was not her job to teach patients how to use PCA pumps but rather it was the pharmacist's job. It is the responsibility of the nurse to make sure the patient is comfortable, and that the patient understands how to utilize the pump after the pharmacist explains its use. This is especially important with post-operative patients who may be groggy when the pump is first explained. The Respondent's care of Patient I fell below the acceptable standard of nursing care.

2.16 In May of 1994, the Respondent failed to explain the use of a PCA pump to another patient who was not identified in the Statement of Charges. As a result, the patient suffered from avoidable pain. The Respondent again claimed it was not her responsibility, but the pharmacist's. Penny Parks, R.N., the Respondent's charge nurse, testified that she counseled the Respondent after receiving the complaint from the patient. Ms. Parks testified that the patient requested to see the charge nurse after the Respondent's shift. The patient was tearful, stating she was in pain most of the evening, because the Respondent did not adequately explain the use of the PCA pump. Exhibit 25 is Ms. Parks' notes from the counseling with the Respondent. It is the responsibility of the Respondent and other nurses to help decrease patients' pain. The Respondent failed to do so, and demonstrates a repeated lack of compassion to this patient and others contained in this case. The Respondent testified that she was not counseled on the use of the PCA pump. Patricia Parks, R.N, Laurie Masters, R.N., and Randy DeJong, R.N., testified to the contrary. These three nurses testified that the Respondent was counseled on the use of the PCA pump.

2.17 On November 3, 1994, Patient J complained about the care received from Respondent, and requested that the Respondent not be assigned to her because the Respondent barely helped her out of bed when she needed aid, and did not follow through with other reasonable, basic patient requests such as leaving on a light. Ms. Parks testified that Patient J complained and requested a different nurse, that the Respondent treated her as though she was a bother, and that therefore Patient J limited her requests. Exhibit 27 contain Ms. Parks counseling notes regarding Patient J's complaint. The Respondent's general denial was vague and not credible.

2.18 On or about November 4, 1994, Patient K complained about the care received from the Respondent and requested that the Respondent not be assigned to him, because the Respondent left her gloves that were soiled with blood or other body

fluid on the floor. Patient K was concerned that his body fluids would contaminate someone else. Ms. Parks testified that Patient K was credible in his statements, because he was a 37-year-old patient who was very knowledgeable regarding his medical condition and aware of the contamination risks. Exhibit 28 contains Ms. Parks' notes regarding Patient K's complaint and some of the patient's medical records. The witnesses and patients repeated descriptions of the Respondent's rushed manner is consistent with this complaint and the Respondent's denial is not credible. She may not have realized that she had thrown the soiled gloves on the floor, but she should have carefully placed the contaminated gloves in a container where patients or staff will not have to pick them up or inadvertently touch them. The Respondent's failure to do so is below the acceptable standard of care.

2.19 The charges alleged that Patient K "complained that the Respondent failed to clean his toilet." Toilet cleaning is not the responsibility of the nursing staff. Ms. Parks testified that Patient K complained that his commode was not cleaned by the Respondent. That is a different issue that was not charged, therefore this allegation related to the toilet should be dismissed.

2.20 On November 13, 1994, the Respondent caused pain to Patient L during a return flow enema. More probably than not, the physical pain resulted from the combination of an enema over a third degree rectocele and the vaginal repair, not the result of alleged roughness by the Respondent. Exhibit 29 contains Patient L's complaint and a portion of her medical records. On November 11, 1994, Patient L had a surgical vaginal repair, therefore it is reasonable to expect that the enema would be painful. Insufficient evidence was presented to sustain the allegation of rough treatment, but the Respondent failed to warn Patient L of the pain and discomfort she should expect from the enema and why. The Respondent failed to be supportive to the patient by talking her through the enema. This failure to communicate demonstrates

the Respondent's lack of empathy that resulted in Patient L's emotional distress. This failure to communicate is below the standard of care. The Respondent first testified that she did not perform the enema on Patient L. The Respondent later admitted performing the enema after the admission of Exhibit 52, the Respondent's nurse progress notes regarding the administration of the enema.

2.21 On December 16, 1994, the Respondent took her dinner break without arranging coverage for her patients. Penny Parks, R.N., testified that the Respondent asked the secretary to watch her patients' lights and to call her if she sees a light. This is not a safe practice, and is below the standard of care. The Respondent should have told a fellow floor nurse of her break, and briefly apprised him or her of any special patient needs that might arise during her dinner break. The Respondent also failed to administer pain medication that had been requested by a patient before taking her dinner break. The Respondent denied these facts, but the testimony of Ms. Parks and Exhibit 30 support this allegation with consistent, specific details.

2.22 On January 6, 1995, Patient M complained that the Respondent touched her scar without gloves and refused to call her doctor after she so requested. If the Respondent touched the scar, it was inadvertent and not below the standard of care. The Respondent's "refusal" to call the doctor was another example of the Respondent's failure to communicate to a patient, in this case the Respondent's plan regarding the patient's increased blood pressure (BP). The Respondent had taken Patient M's BP, and it was elevated. Patient M was aware of the high BP reading and of her seizure history and risk, so Patient M asked the Respondent to call her doctor. The Respondent did not, and she did not explain to Patient M why not. Her plan was to call the doctor if the BP remained high after rechecking the BP. This plan was within the acceptable standard of care, but the failure to explain the plan to Patient M was not within the acceptable standard of nursing care. The patient was not physically harmed,

but Patient M suffered unnecessary emotional harm as a result of the lack of communication. Ms. Parks testified that it was particularly important to keep this patient well informed, to decrease anxiety, since Patient M had a history of seizures.

2.23 On January 12, 1995, the Respondent refused to catheterize a male patient, pursuant to the patient's request that a male nurse administer the catheter. The Respondent's refusal was reasonable, therefore the charge contained in paragraph 1.3(I) should be dismissed. Testimony was presented that the Respondent always refused to catheterize male patients. The Respondent denied that she categorically refused to catheterize patients. This allegation was not included in the Statement of Charges and therefore will not be addressed.

2.24 On March 3, 1994, the Respondent failed to change Patient N's chest tube. On page four of Exhibit 34, the 0020 (12:20 a.m.) nurse progress note states that the nurse following the Respondent's shift found the pleura evacuation tube full. The tube would not have filled up as quickly as the Respondent testified, between the end of the Respondent's shift at 11:00 p.m. and 12:20 a.m. when the relief nurse noted the full tube. Pages one through three of Exhibit 49 contain the hospital's nursing protocol in the care of patient chest tubes. The maintenance section outlines when the tube shall be changed. The Respondent's testimony was not consistent or credible. She first testified that she changed the tube at the end of her shift. She later testified that she did not change the tube because it took too much time, and that her relief nurse changed the tube. The Respondent's failure to change the tube is below the standard of care. The remaining allegations contained in paragraph 1.3.H. of the Statement of Charges are not related to Patient M as charged, therefore those charges should be dismissed.

2.25 On April 5, 1995, the Respondent failed to complete an unusual occurrence report regarding Patient O's fall. This seventy-year-old patient fell on the

floor, and as a result suffered from left hip pain and skin abrasion bellow the knee. The 1745 nurse progress note on page eight of Exhibit 37 describes the fall and resulting injuries. The Respondent's failure to complete the report regarding the fall is below the standard of care. Ms. Parks' testimony and pages five through eight of Exhibit 49 state the hospital policy and reasons for this precaution in case complications arising later from a patient fall. Exhibit 37 also contains Myrta Stillwell, R.N.'s statement regarding the Respondent's refusal to complete the form. Ms. Stillwell wrote that even after careful "explanation of the need" to the Respondent of the "potential complications" to a patient who sustains abrasions, the Respondent refused to complete the form. The Respondent told Ms. Parks that she knew she was to fill out the report, but she forgot to fill out the form. Page two of Exhibit 37 contains Ms. Parks' counseling notes regarding the Respondent's failure to complete the unusual occurrence report. The Respondent testified that she completed all of the form except the date and later testified that she filled the form out after she was counseled. The Respondent's testimony is inconsistent and not credible.

2.26 Insufficient evidence was presented to sustain the allegation that on April 18, 1995, the Respondent went to dinner and left Patient P, a post-operative patient with seizure disorder, in an uncontrolled state. Exhibit 38, Patient P's medical records indicate that the patient's care did not significantly change after the seizure that had occurred during the Respondent's break. The doctor did not change his orders nor the nursing care significantly change.

2.27 Insufficient evidence was presented to support the allegation that on or about March 17-19, the Respondent failed to follow through with the needs of Patient Q, and failed to communicate any procedures or plan of care. The testimony of Ms. Parks did not support this allegation. She testified that she did not recall this patient or the nature of the complaint. Exhibit 40 is Ms. Parks' notes regarding

Patient Q's complaint. These vague, unsubstantiated notes are insufficient evidence to fulfill the Department's burden of proof.

2.28 On March 21 and 22, 1995, the Respondent failed to follow through with the needs of Patient R. Patient R wrote and signed a complaint regarding the care received from the Respondent, page two of Exhibit 41. The patient wrote a clear and detailed statement describing the Respondent's substandard care, such as refusing to help her remove her leg from a CPM device. Patient R stated that she thought the Respondent "has a difficult time relating with the patients, and has to learn to listen closer to patients and be considerate." Patient R also ended her complaint with this empathetic statement, "If she (Respondent) had personal problems, I'm sorry as we all have our problems." The Respondent did not testify that she was having personal problems, or a bad day to explain her inconsiderate denial to help this patient do tasks she was unable to perform alone or at all. The Respondent testified that these allegations were fabricated, and that she never is inconsiderate to a patient. This denial is not credible in light of the detailed, empathetic complaint Patient R personally wrote and signed the day after the Respondent cared for Patient R.

2.29 On April 5, 1995, the Respondent turned Patient S's call light off and ignored her requests for assistance. The testimony of Emily Carter, R. N., and page three of Exhibit 42 support this finding. Ms. Carter testified that the patient had left shoulder surgery and was unable to write, so Ms. Carter wrote out the complaint as the patient requested. Patient S did sign the complaint that stated the Respondent had "no compassion." The Respondent told Patient S that she could do tasks that the patient was not capable of performing, and then the Respondent turned off the patient's call light. Ms. Carter testified that Patient S was oriented, aware of what was going on and therefore was credible. The Commission finds Ms. Carter's testimony and the written complaint of Patient S logical, consistent, and credible, and the Respondent's general

denial and statement that she did not see the patient complaint when she was employed at Providence unpersuasive, considering that her employment at Providence ended in May of 1995, soon after she cared for Patient S.

2.30 On April 11, 1995, the Respondent turned Patient T using an incorrect manner and caused intense pain, and the Respondent failed to follow through with the needs of Patient T. This 68-year-old patient needed to be frequently turned due to his sedentary state from paraplegia and recently developed cellulitis and degenerating sacral decubitus. The Respondent turned the patient to his right side by holding the patient's left wrist and pulling him over, causing "intense pain in the arm and shoulder area." Patient T told the Respondent while she was pulling that she was causing great pain, but the Respondent continued to do so until the patient grabbed her wrist with his right hand to make the Respondent stop. The Respondent also did not attend to Patient T's needs, such as requests for a blanket and aid in unfolding a blanket, that she brought only after repeated requests, and then threw the blanket on the patient's chest. Patient T only had use of one arm. Penny Parks, R.N., testified that Patient T complained to her, and that her documentation of his complaint is in Exhibit 43. Ms. Parks testified that Patient T was alert, oriented, very specific and credible in his concerns and complaints. Patient T stated to Ms. Parks that his overall concern is that the Respondent works in a "non-caring manner," and that "she could really hurt someone." The detailed, specific facts provided by Parks' testimony and Exhibit 43 clearly support the findings that the Respondent not only provided substandard care but was cruel to Patient T. The Respondent's denial that she turned the patient in this very rough manner, and her assertion that the x-ray staff failed to supply the blanket, were not persuasive. The Respondent provided no reason why this patient would fabricate this detailed description of the unsafe rough manner to be turned, and there was more

than one occasion when the Respondent did not supply a blanket or when she failed to unfold it and simply tossed it on the patient.

2.31 On May 14, 1995, the Respondent spilled bloody fluid on the bed, floor, and toilet of Patient U, jerked up the support stockings on Patient U's leg causing pain, and was rough when she turned the patient. The Respondent was abrupt and rude to Patient U when she complained of discomfort from her post-surgical drains pulling while the Respondent was rolling her to her side. The Respondent told the patient that drains do not hurt other people, and then let the patient flop back onto her back causing great discomfort. On the day of this rough treatment, Patient U wrote her complaint on the Patient Feedback Memo, page four of Exhibit 45. On May 16, 1995, Patient U's partner called Providence and complained about the care Patient U received. He and Patient U felt the Respondent was "insensitive." Page 6 of Exhibit 45 is a typewritten summary of the conversation. The Respondent's general denial that this did not occur is not credible in light of the patient's detailed written complaint and Exhibit 45.

2.32 The Respondent presented two witnesses in her defense, but neither witness provided supportive testimony regarding the Statement of Charges or the care the Respondent provided to patients. Tresita Morales, R.N., testified that she worked at Providence only on a few shifts with the Respondent. Ms. Morales testified that she did not have the opportunity to observe and could not recall the quality of care the Respondent provided to patients. Wendy Jackson, R.N., one of the Respondent's charge nurses at Providence, testified that there were many patient complaints regarding the Respondent's care, often that the Respondent was rough, uncaring and demonstrated a lack of compassion. Ms. Jackson testified that she counseled the Respondent, but after a time talking to the Respondent became useless. Ms. Jackson started writing down the problems and referred those problems to her supervisor, Laurie Masters, R.N. Ms. Jackson contradicted the Respondent's own testimony. For

example, the Respondent testified that she was not counseled or told that patients complained that she was not caring or compassionate. Ms. Jackson not only testified to that fact, but it is in the Respondent's evaluations on page 11 of Exhibit 51.

2.33 The Respondent's and the Department's witnesses provided consistent testimony that there were many credible patient complaints. There was a pattern. The Respondent often refused to help patients perform tasks that were difficult or impossible for the patient to perform. The Respondent did not take the time or show empathy to patients through explanation of the treatment plan or procedure or use of the medication. There were repeated complaints of the lack of compassion causing the patients to suffer physical and emotional discomforts. On a few occasions, the Respondent was not only inconsiderate and failed to provide adequate nursing care, but she abused Patients F, L, M and T. The above findings demonstrate a lack of understanding in the administration of medications and other treatments, as well as great need to improve communication skills so that acceptable care is provided to patients.

III. CONCLUSIONS OF LAW

Based upon the Findings of Fact, the Commission makes the following Conclusions of Law:

3.1 The Commission has jurisdiction over the Respondent, Aleyamma Thomas, R.N., and over the subject matter of this proceeding.

3.2 The Department has the burden of proving the allegations in the Statement of Charges. The preponderance of evidence standard applies in disciplinary proceedings.

3.3 Based on the Findings of Fact 2.7, 2.11, 2.23, 2.26 and 2.27, the Commission concludes that the Department has failed to prove by a preponderance of

evidence that the Respondent's treatment of Patients A, P, Q, the unidentified patient in finding 2.23, Patient F only as it relates to the bedpan, and Patient K as it relates to the toilet fell below the standards of care. As a result, the allegations in paragraphs 1.2.C, 1.2.E, 1.3.L, 1.3.M.i, the toilet related allegation in paragraph 1.3.E and the bedpan related allegation in paragraph 1.3.A.i of the Statement of Charges should be dismissed.

3.4 The allegations in paragraph 1.3.I of the charges was proved with a preponderance of the evidence (finding 2.23), but the Respondent's conduct described in paragraphs 2.23 does not constitute the Commission of unprofessional conduct. As a result the allegations in paragraph 1.3.I of the Statement of Charges should be dismissed.

3.5 The Respondent's conduct described in paragraphs 2.2, 2.3, 2.4, 2.6, 2.8, 2.10, 2.12 through 2.18, 2.20, 2.21, 2.22, 2.24, 2.28, 2.29, 2.30 and 2.31 violates RCW 18.130.180(4), (7) and WAC 246-839-700(1)(b).

3.6 The Respondent's conduct in paragraph 2.22 violates WAC 246-130-700 (1)(c).

3.7 The Respondent's conduct in paragraph 2.25 violates WAC 246-839-700 (1)(a) and (1)(c).

3.8 The Respondent's conduct described in paragraphs 2.12 through 2.18, 2.21, 2.22, 2.23, 2.24, 2.28, 2.29, 2.30, and 2.31 violates WAC 246-839-710(1)(a).

3.9 The Respondent's conduct described in paragraphs 2.24 and 2.25 violates WAC 246-839-710(1)(b).

3.10 The Respondent's conduct in paragraphs 2.4 and 2.8 violates WAC 246-839-710(1)(c).

3.11 The Respondent's conduct described in paragraphs 2.3, 2.4, 2.6, 2.8, 2.9, 2.10, 2.15, 2.16 and 2.31 violates WAC 246-839-710(1)(d).

3.12 The Respondent's conduct described in paragraphs 2.12, 2.20, 2.22 and 2.30 violates WAC 246-839-710(1)(f).

3.13 The Respondent's conduct described in paragraph 2.21 violates WAC 246-839-710(4)(c).

IV. ORDER

Based on the foregoing Findings of Fact, and Conclusions of Law, the Commission hereby makes the following ORDERS:

4.1 The allegations in paragraphs 1.2.C, 1.2.E, 1.3.I, 1.3.L and 1.3.M.i, the allegation related to the bed pan in paragraph 1.3.A.i, and the allegation related to the toilet in paragraph 1.3.E in the Statement of Charges are DISMISSED with prejudice.

4.2 The license to practice as a registered nurse in the state of Washington issued to Aleyamma Thomas, R.N., is SUSPENDED until such time as the Commission determines that the Respondent has successfully completed a Commission-approved refresher course, as outlined below. Upon the Respondent's successful completion of this course, the Respondent's suspension shall be STAYED upon the Respondent's compliance with the terms and conditions set forth in this Order for a period of twenty-four (24) months.

4.3 The Respondent shall immediately execute all release of information forms as may be required by the Commission or its designee.

4.4 The Respondent shall present both portions of her license to the Commission to be stamped "suspended" within ten (10) days of the receipt of this Order. After successful completion of the Commission-approved refresher course, the Respondent shall ensure that all subsequent licenses received during the term of this Order are stamped "probation" and shall immediately return any license to the Commission that is not stamped "probation."

4.5 The Respondent shall be granted a limited educational license when she is accepted into a Commission-approved refresher course.

a. Prior to the start or commencement of the refresher course, the Respondent shall ensure that the refresher course instructor has been shown a complete copy of the Findings of Fact, Conclusions of Law and Order (Order), and shall cause the refresher course instructor to provide a written statement to the Commission that he or she has received a copy of the Order and has accepted the Respondent into the refresher course.

b. The Respondent will complete a refresher course within twelve months of commencing the course on a probationary license.

c. The Respondent shall submit proof to the Commission or its designee of successful completion of the refresher course.

4.6 The Respondent shall subsequently provide evidence to the Commission that she had completed the refresher course providing theoretical instruction and supervised clinical practice in communication with patients, attending to patient emotional and physical needs, and administration of medication. The refresher course must be taken at an accredited educational institution approved by the Commission.

4.7 The Respondent shall subsequently submit evaluative data from the course taken, including a personal description of her experience and her instructor's evaluation of her performance and any recommendation regarding any further training or work conditions/limitations.

4.8 The Respondent shall not use her license to obtain employment as a nursing assistant, home health aide or other health care provider.

4.9 The Respondent shall submit personal progress reports directly to the Commission, on forms supplied by the Commission, dealing with her methods of handling stress, methods of dealing with legal charges, professional responsibilities and

activities and personal activities as they relate to the practice of nursing and improving her nursing skills in the area of communication, attending to patients' emotion and physical needs and the administration of medications. The first report shall be due August 1, 1997, and the reports shall be submitted every six months thereafter unless otherwise ordered by the Commission.

4.10 The Respondent shall notify the Commission of current and future employment in the health care field, by submitting a job description directly to the Commission within ten (10) days of receipt of this Order or change in employment.

a. The Respondent shall cause her registered nurse supervisor to submit performance evaluation reports directly to the Commission on forms provided by the Commission. The first report shall be due ^{August 1,} 1997 and reports shall be submitted every three (3) months thereafter, until otherwise ordered by the Commission.

b. The Respondent shall provide a copy of this Findings of Fact, Conclusion of Law, and Order to her current and future employers and ensure that the employer understands the Commission's decision in this case.

c. The Respondent shall cause all employers (current and future) to inform the Commission in writing of the employer's knowledge of this Findings of Fact, Conclusion of Law and Order within ten (10) days of commencing employment.

4.11 During the stayed suspension period, the Respondent shall be employed as a registered nurse in the state of Washington only upon compliance with the following terms and conditions:

a. The Respondent shall not accept employment as a registered nurse without prior approval from the Commission.

b. The Respondent shall not work a shift within twelve hours of the previous shift.

c. The Respondent shall not work nights.

- d. The Respondent shall not float from unit to unit.
- e. The Respondent may not work where she is the only registered nurse.
- f. The Respondent shall not be employed by a nurses' registry, home health care, assisted living facilities, adult family homes or other temporary agencies.
- g. The Respondent shall be employed as a registered nurse only in a setting in which direct supervision is provided, and may not function as a supervisor, head nurse or charge nurse.

4.12 The Respondent shall not violate any law or regulation regarding the practice of registered nursing.

4.13 During the period of the unstayed suspension, the Respondent shall not make public appearances representing herself as a registered nurse.

4.14 Any and all costs involved in complying with this Order shall be borne by the Respondent.

4.15 Any failure to comply with the conditions imposed by the Commission will be grounds for further sanctions against the Respondent's license to practice as a registered nurse in the state of Washington.

4.16 The Respondent may submit a written request for modification of the Commission's order no sooner than twelve (12) months from the date of this Order.

- a. The Respondent need not appear before the Commission, but must appear before one of the Commission members who heard this case, and participated in the deliberations and issuance of this Order.

- b. At the discretion of a Commission member who heard this case, and participated in the deliberations and issuance of this Order, the terms and conditions of this Order may be modified without a modification hearing.

c. The Respondent must show satisfactory compliance with the terms and conditions imposed in this Order.

d. The Commission may impose additional conditions after reviewing the submitted reports and the Respondent's compliance with this Order.

4.17 The Respondent may submit a written request for reinstatement of her license to practice as a registered nurse in the state of Washington no sooner than 36 months from the date of this Order.

a. The Respondent must personally appear before the one of the Commission members who heard this case and participated in the deliberations and issuance of this Order.

b. The Respondent must show satisfactory compliance with the terms and conditions imposed in this Order.

c. The Commission may impose additional conditions after reviewing the submitted reports and the Respondent's compliance with this Order.

As provided by RCW 34.05.440(3), the party against whom this Order is entered may file a written motion requesting that this Order be vacated. The petition must be filed within seven days of service of this Order with the Nursing Care Quality Assurance Commission, PO Box 47864, Olympia, Washington 98504-7864, and a copy sent to the Office of Professional Standards, 2413 Pacific Avenue, PO Box 47872, Olympia, Washington 98504-7872. The motion must state the specific grounds relied upon. The motion to vacate shall not stay the effectiveness of this Order.

"Filing" means actual receipt of the document by the Commission. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 43.05.010(18).

Proceedings for judicial review may be instituted by filing a petition in the superior court in accordance with the procedures specified in Chapter 34.05 RCW,

Part V, Judicial Review and Civil Enforcement. The petition for judicial review must be filed within 30 days after the service of this Order, as provided in RCW 34.05.542.

DATED THIS 20 DAY OF JUNE, 1997.

Nursing Care Quality Assurance Commission

Rebecca (Becky) Kerben, L.P.N.
BECKY KERBEN, L.P.N., Chair

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION**

In the Matter of the License to Practice as a Registered Nurse of:)	Docket No. 02-08-A-1041RN
)	
ALEYAMMA THOMAS, RN, Credential No. RN00104070)	STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND
Respondent.)	AGREED ORDER
_____)		

The Nursing Care Quality Assurance Commission (Commission), by and through, Janet Staiger, Department of Health Staff Attorney and Aleyamma Thomas, RN, represented by counsel, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

- 1.1 Aleyamma Thomas, RN Respondent, was issued a license to practice as a registered nurse by the state of Washington in October 1990.
- 1.2 On October 21st, 2002, the Commission issued a Statement of Charges against Respondent.
- 1.3 The Statement of Charges alleges that Respondent violated RCW 18.130.180(9).
- 1.4 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.
- 1.5 Respondent understands that she has the right to defend herself against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.6 Respondent understands that, should the State prove at a hearing the allegations in the Statement of Charges, the Commission has the power and authority to impose sanctions pursuant to RCW 18.130.160.

1.7 Respondent and the Commission agree to expedite the resolution of this matter by means of this Stipulated Finding of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.8 Respondent waives the opportunity for a hearing on the Statement of Charges contingent upon signature and acceptance of this Agreed Order by the Commission.

1.9 This Agreed Order is not binding unless and until it is signed and accepted by the Commission.

1.10 Should this Agreed Order be signed and accepted it will be subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements.

1.11 Should this Agreed Order be rejected, Respondent waives any objection to the participation at hearing of all or some of the Commission members who heard the Agreed Order presentation.

Section 2: STIPULATED FACTS

The State and Respondent stipulate to the following facts:

2.1 Aleyamma Thomas, RN, Respondent, was issued a license to practice as a registered nurse by the state of Washington in October 1990.

2.2 On June 20, 1997, Findings of Fact, Conclusions of Law, and Order (Order) was entered In the Matter of the License to Practice as a Registered Nurse of: Aleyamma Thomas, RN,

OPS No. 96-10-10-530RN. Pursuant to the Order, Respondent was required to comply with certain terms and conditions including, but not limited to the following:

- a. The Respondent will complete a refresher course within twelve months of commencing the course on a probationary license. (Paragraphs 4.2 and 4.5 of Order)
- b. The Respondent shall subsequently provide evidence to the Commission that she has completed the refresher course providing theoretical instruction and supervised clinical practice in communication with patients, attending to patients' emotional and physical needs, and administration of medication. The refresher course must be taken at an accredited educational institution approved by the Commission. (Paragraph 4.6 of Order)
- c. The Respondent shall submit personal progress reports directly to the Commission, on forms supplied by the Commission, dealing with her methods of handling stress, methods of dealing with legal charges, professional responsibilities and activities and personal activities as they relate to the practice of nursing and improving her nursing skills in the area of communication, attending to patients' emotional and physical needs and the administration of medications. The first reports shall be due August 1, 1997, and reports shall be submitted every six months thereafter unless otherwise ordered by the Commission. (Paragraph 4.9 of Order)

2.3 Respondent has not provided evidence of completion of the refresher course to the Commission, referenced above in Paragraph 1.2(a), (b).

2.4 Respondent has not continued to fulfill her obligation to provide personal progress reports to the Commission.

Section 3: CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 This Agreed Order supersedes all previous Orders entered in this matter, including the Agreed Order entered in June 1997 and referenced above in paragraph 2.2.

3.3 The above facts set forth in paragraphs 2.2 through 2.4 constitute unprofessional conduct in violation of RCW18.130.180(9).

3.4 The above violations are grounds for the imposition of sanctions under RCW 18.130.160.

Section 4: AGREED ORDER

Based on the preceding Stipulated Facts and Conclusions of Law, Respondent agrees to entry of the following Agreed Order:

4.1 Respondent's license shall remain SUSPENDED until such time that the Respondent is accepted into a Commission-approved refresher course. After Respondent is accepted into the refresher course, her license shall be REINSTATED but subject to PROBATION.

The conditions of probation include:

- A. Respondent shall ensure that all licenses received during the term of probation are stamped "probation" and shall immediately return any license to the Commission that is not stamped "probation".
- B. Respondent may not practice as a RN except as part of a Commission-approved refresher course, referenced in WAC 246-840-130.
- C. Respondent shall provide a copy of this Agreed Order to the refresher course instructor. Respondent shall cause the instructor to furnish written confirmation to the Commission that a copy of the Agreed Order has been provided.
- D. The respondent must provide proof of successful completion of the approved refresher course by submitting supporting documents to:

Nursing Care Quality Assurance Commission
Attention: Compliance Officer
P.O. Box 477864
Olympia, WA 98504-7864

4.2 Upon proof of successful completion of the refresher course, the conditions of probation referenced above in paragraph 4.1 no longer apply. After such time, Respondent's license shall remain on PROBATION for a period of twelve (12) months from the date that Respondent notifies the Commission of successful completion of the refresher course, with the following conditions:

- A. Respondent shall cause her nurse supervisor to submit performance evaluation reports directly to the Commission on forms provided by the Commission. The first report shall be due forty-five (45) days from the date that the Respondent notifies the Commission of successful completion of the

refresher course. After such time, reports shall be submitted every three (3) months.

- B. Respondent shall provide a copy of this Order to her future employers and ensure that the employer understands the Commission's decision in this case. Respondent shall, within ten (10) days, cause all employers (current and future) to inform the Commission in writing of the employer's knowledge of this Order.

4.3 Respondent may submit a written request for modification of the Commission's Order no sooner than twelve (12) months from the date of this Order and/or reinstatement of her license no sooner than twelve (12) months from the date that Respondent notifies the Commission of her successful completion of the refresher course.

- A Respondent must at that time be prepared to provide proof of satisfactory compliance with the terms and conditions imposed in this Order.
- B. Respondent must personally appear before the Commission at any such hearing, however, at the discretion of a Reviewing Commission Member, the terms and conditions of this Order may be modified through an Agreed Order, or the Respondent's license reinstated without a hearing.
- C. Upon notice and an opportunity for Respondent to be heard, the Commission may impose additional conditions after reviewing the documents submitted and reviewing the Respondent's compliance with this Order.

4.4 Respondent shall not violate any law or regulation regarding the practice of nursing.

4.5 Respondent shall assume all costs of complying with this Order.

4.6 Respondent shall immediately execute all release of information forms as may be required by the Commission or its designee.

4.7 Respondent shall not make public appearances representing herself as a licensed registered nurse, until she has successfully completed a refresher course.

4.8 Any failure to comply with the terms and conditions of this Order shall subject Respondent's license to practice to further disciplinary action.

4.9 Respondent shall inform the Commission and the Adjudicative Clerk Office in writing, of changes in her residential and/or business address within thirty (30) days of such change.

I, Aleyamma Thomas, RN, Respondent, certify that I have read this Stipulated Findings of Fact, Conclusions of Law and Agreed Order in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Commission without my appearance. If the Commission accepts the Stipulated Findings of Fact, Conclusions of Law and Agreed Order, I understand that I will receive a signed copy.

A Thomas
Aleyamma Thomas, RN
Respondent

5/5/03
Date

[Signature]
Sarah L. Hurst, WSBA #29489
Attorney for Respondent

5/5/03
Date

Section 5: ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED this 4 day of June, 2003.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE
QUALITY ASSURANCE COMMISSION

Frank T. Wajonicki, CRN, MS
Panel Chair

Presented by:

Janet Staiger
Janet Staiger, WSBA #16573
Department of Health Staff Attorney

July 7, 2003
Date

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:
Program No. 2002-05-0039RN

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION**

In the Matter of the License to Practice as a
Registered Nurse of:

ALEYAMMA THOMAS, RN
Credential No. RN00104070

Respondent.

Docket No. 02-08-A-1041RN

ORDER ON REINSTATEMENT

This matter comes before the Washington State Nursing Care Quality Assurance Commission (Commission) on February 4, 2005, pursuant to a request for reinstatement brought by Respondent and / or Trent Kelly, Department of Health Staff Attorney. The Commission, by and through, Susan Wong, RN, Reviewing Commission Member, having reviewed the record, issues the following:

Section 1: PROCEDURAL HISTORY / FINDINGS OF FACT

1.1 On September 13, 1996, the Commission issued a Statement of Charges alleging Respondent had violated RCW 18.130.180 (4), (7) and WAC 246-839-700 (1)(b) and WAC 246-839-710 (1)(a), (c), (d) and (f).

1.2 On June 20, 1997, the Commission issued a Stipulated Findings of Fact, Conclusions of Law and Order (Order) in the matter whereby Respondent's nursing license was suspended until Respondent successfully completed a Commission-approved refresher course. Upon successful completion of this course, the Respondent's suspension was stayed and

Respondent was placed on probation for an initial twenty-four (24) month period, subject to compliance with a number of terms and conditions.

1.3 On or about July 15, 1998, Respondent made a written request for modification of the terms of the June 20, 1997, Order.

1.4 On August 18, 1998, the Commission issued a Stipulated Findings of Fact, Conclusions of Law and Order on Petition for Modification (Order) in the matter whereby Respondent's request was denied. The June 20, 1997, Order remained in full force and effect.

1.5 On October 21, 2002, the Commission issued a Statement of Charges alleging Respondent had violated RCW 18.130.180 (9).

1.6 On June 4, 2003, the Commission issued a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Order) in the matter whereby Respondent's nursing license remained suspended until Respondent was accepted into a Commission-approved refresher course. After Respondent was accepted into the refresher course, her license would be reinstated but subject to probation subject to compliance with a number of terms and conditions.

1.7 On or about February 4, 2005, Respondent made a written request for reinstatement of the terms of the June 4, 2003, Order.

1.8 At the Department's request, the Reviewing Commission Member assigned to this matter reviewed Respondent's file to determine her compliance with the current Order. The Reviewing Member concluded from the compliance record that Respondent had substantially complied with the terms and conditions of the current Order and is safe to practice nursing with an unrestricted license. An Order should be entered directing that Respondent be released from the terms and conditions of the Order dated June 4, 2003, Order.

Section 2: CONCLUSIONS OF LAW

From the Foregoing Findings of Fact, Conclusions of Law and Agreed Order the Commission makes the following Conclusions of Law:

2.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

2.2 Respondent is in compliance with the Stipulated Findings of Fact, Conclusions of Law and Agreed Order dated June 4, 2003, and an Order should be entered terminating the Commission's oversight and monitoring of Respondent's compliance and releasing Respondent from the Order.

Section 3: ORDER

Based on the foregoing Procedural history / Findings of Fact and Conclusions of Law, the Commission hereby ORDERS:

3.1 Respondent is released from all terms and conditions of the Stipulated Findings of Fact, Conclusions of Law and Agreed Order dated June 4, 2003, the Commission's oversight and monitoring of Respondent's compliance is terminated, and Respondent's license to practice nursing in the state of Washington is fully reinstated without limitation or restriction commencing the date of entry of this Order on Reinstatement; further,

3.2 That this Order shall be reported statewide and nationally pursuant to RCW 18.130.110.

DATED this 23rd day of FEBRUARY, 2005.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

Susan Wong RN
Susan Wong, RN
Commission Member

Presented by:

Trent Kelly
Trent Kelly, WSBA #16123
Department of Health Staff Attorney

2/28/05
Date

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:
Program No. 2002-05-0039RN