

BEFORE THE TEXAS BOARD OF NURSING



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.  
*Patricia P. Thomas*  
Executive Director of the Board

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In the Matter of Vocational Nurse           §       AGREED  
License Number 37694, issued to           §  
BRENDA JOYCE KRINHOP                   §       ORDER

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Vocational Nurse License Number 37694, issued to BRENDA JOYCE KRINHOP, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

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

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

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was provided to Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Respondent waived notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice vocational nursing in the State of Texas.
4. Respondent received a Certificate in Vocational Nursing from the School of Vocational Nursing, Memorial Hospital, Houston, Texas, in 1967. Respondent was licensed to practice vocational nursing in the State of Texas on July 29, 1967.
5. Respondent's nursing employment history includes:

1967	LVN Staff Nurse	Lufkin Memorial Hospital Lufkin, Texas
1968	LVN Staff Nurse	Johnson County Memorial Hospital Franklin, Indiana

Respondent's nursing employment history continued:

1969	LVN Staff Nurse	Memorial Baptist Hospital Houston, Texas
1970	LVN Staff Nurse L & D/Nursery	Sacred Heart Catholic Hospital Pensacola, Florida
1971 - 1983	Not employed in nursing	
11/83 - 06/84	Private Duty Nurse	RN Professionals, Inc. Lufkin, Texas
03/85 - 06/88	Office Manager Pediatric Nurse	Office of Dr. McCall Lufkin, Texas
10/89 - 10/90	LVN	Texas Home Health Lufkin, Texas
10/90 - 07/01	LVN Staff Nurse	Memorial Health Center Lufkin, Texas
1995 - 1997	LVN Staff Nurse Parttime	MHMR Burke Center, Pineywoods Hospital Lufkin, Texas
07/01 - 01/02	LVN Staff Nurse	Pinecrest Methodist Retirement Center Lufkin, Texas
02/02 - 09/02	LVN Staff Nurse	Trinity Mission Rehabilitation Center Diboll, Texas
09/02 - 02/04	LVN Staff Nurse	UTMB, Correctional Managed Care Diboll, Texas
03/04 - 08/05	LVN Staff Nurse	Trinity Mission Rehabilitation Center Diboll, Texas
08/05 - 07/07	LVN Staff Nurse	Hillside Plaza Wells, Texas
07/07 (3 days)	LVN Staff Nurse	Memorial Medical Center Lufkin, Texas

Respondent's nursing employment history continued:

07/07 - 09/07	LVN Staff Nurse	Grace Care Lufkin, Texas
09/07 - 07/09	LVN Charge Nurse	Hillside Plaza Wells, Texas
08/09 - Present	Unknown	

6. At the time of the incidents, Respondent was employed as LVN Charge Nurse with Hillside Plaza, Wells, Texas, and had been in this position for one (1) year and ten (10) months.
7. On or about July 14-15, 2009, while employed with Hillside Plaza, Wells, Texas, Respondent failed to assess and evaluate the status of Patient Medical Record Number 1104 during her entire shift from 10:00 p.m. - 6:00 a.m. Patient Medical Record Number 1104 had a Wander Guard bracelet that was not properly placed and functioning. The patient was found dead outside the facility by the day shift at 6:00 a.m. She had wandered outside where she had fallen and suffered a large bruise to her forehead.
8. On or about July 14-15, 2009, while employed with Hillside Plaza, Wells, Texas, Respondent initialed the Treatment Record of Patient Medical Record Number 1104 by verifying that she checked the patient's Wander Guard bracelet, however Respondent later admitted that she had not seen the patient for her entire shift.
9. On or about July 14-15, 2009, while employed with Hillside Plaza, Wells, Texas, Respondent failed to supervise the nursing care provided by the Certified Nurse Aides (CNAs) for whom she was professionally responsible. The CNAs were assigned to make rounds on the patients every two (2) hours, including Patient Medical Record Number 1104. In addition, Respondent failed to report to the Physician, Director of Nursing, Administrator and the Family that Patient Medical Record Number 1104 was missing from the facility after she was notified by the CNA at 4:30 a.m. Patient Medical Record Number 1104 wandered outside the facility where she was found dead by the day shift at 6:00 a.m. The patient suffered a fall and had a large bruise to her forehead.
10. In response to Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that she acknowledges that she never saw Patient Medical Record Number 1104 during the time from 10:00 p.m. to 4:45 a.m. She relied on the reports of the CNAs, that they had checked on each patient every two hours. Delegating this responsibility to the CNA's was both pursuant to the procedures of the institution and within the proper standard of care. She would have seen every patient during a final walk through before the end of her shift. In particular, she would have seen Patient Medical Record Number 1104 while dispensing medication around 5:30am. The Wander Guard was not, in reality, a fully functioning system at this institution. None of the staff to her knowledge, had ever been given any

training on the Wander Guard System. She was never provided with any documentation or instructions on its use. It was an open secret that the Wander Guard was not actually functioning. The first policy regarding the use of Wander Guard System was provided to staff on July 17, 2009, three days after the incident. She states that she made a serious mistake in going along as she did, both the Director of Nursing and the Administrator knew that this condition existed. Regarding the documentation on the Treatment Record for the Wander Guard System, anytime that she left any of the blocks unchecked/un-initialed, the administration staff would bring the records back to her in a batch with an order to check all the boxes. Respondent believes that the patient was not present in the facility at the beginning of the 10:00 p.m. shift. The CNA noted that her room was empty at 10:00pm. Additionally, the patient was found wearing the same clothing she had been dressed in that morning. She was notified that the patient was missing at approximately 4:45am and they immediately began a full house search. Sometime around 5:20am - 5:30am, the patient was discovered outside A Hall by an incoming staff member. She went outside to check on the patient's condition and determined that she was deceased. Before she entered the building she was told by a CNA that the Administrator and Director of Nursing had been notified.

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

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B),(D),(M),(U)&(2)(B).
4. The evidence received is sufficient cause pursuant to Section 301.453(a), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 37694, heretofore issued to BRENDA JOYCE KRINHOP, including revocation of Respondent's license to practice nursing in the State of Texas.
5. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.
6. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.
7. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Vocational Nurse License Number 37694, heretofore issued to BRENDA JOYCE KRINHOP, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing.

In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying herself as a vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a vocational nurse during the period in which the license is surrendered.
2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.
3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

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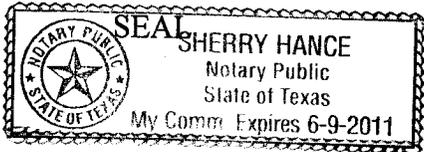
RESPONDENT'S CERTIFICATION

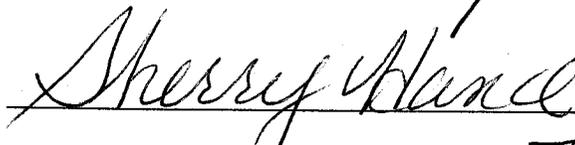
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid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

Signed this 16 day of Feb, 20 11.

  
BRENDA JOYCE KRINHOP, Respondent

Sworn to and subscribed before me this 16 day of February, 20 11.



  
Notary Public in and for the State of Texas

Approved as to form and substance.

  
Scott Tatum, Attorney for Respondent

Signed this 16 day of Feb-, 20 11.

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Vocational Nurse License Number 37694, previously issued to BRENDA JOYCE KRINHOP.

Effective this 7<sup>th</sup> day of March, 2011.



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