

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.  
*Katherine A. Thomas*  
Executive Director of the Board

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In the Matter of Registered Nurse § AGREED  
License Number 728131, and §  
Vocational Nurse License §  
Number 116893 issued to § ORDER  
BARBARA BRYANT MCKINNEY §

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of BARBARA BRYANT MCKINNEY, Registered Nurse License Number 728131, and Vocational Nurse License Number 116893, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on July 25, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Respondent waived 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, and holds a license to practice vocational nursing in the State of Texas, which is in inactive status.
4. Respondent received a Certificate in Practical Nursing from Jonesboro-Hodge High School, Jonesboro, Louisiana, on May 1, 1979. Respondent was licensed to practice vocational nursing in the State of Texas on February 20, 1987. Respondent received an Associate Degree in Nursing from Trinity Valley Community College, Kaufman, Texas, on May 8, 2006. Respondent was licensed to practice professional nursing in the State of Texas on June 6, 2006.

5. Respondent's nursing employment history includes:

|                  |                                 |  |
|------------------|---------------------------------|--|
| 1979 - 3/2001    | Unknown                         |  |
| 4/2001 - 11/2005 | Assistant Director<br>of Nurses | Windsor Place<br>Lancaster, Texas            |
| 12/2005 - 5/2006 | Unknown                         |  |
| 6/2006 - 9/2007  | Director of Nurses              | Town East Rehab<br>Mesquite, Texas           |
| 3/2008 - 6/2009  | Director of Nurses              | Duncanville Healthcare<br>Duncanville, Texas |
| 7/2009 - Present | Unknown                         |  |

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, and had been in this position for nine (9) months.
7. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to supervise the nursing staff to ensure the physician's orders were implemented in a timely manner when a Roho cushion was ordered for Resident DS on December 31, 2008, and was not provided until January 8, 2009. Respondent's conduct may have deprived the resident of timely intervention and contributed to increased severity of the pressure ulcer.
8. In response to the incident in Finding of Fact Number Seven (7), Respondent states the wound care specialist ordered the Roho cushion on December 31, 2008 at 17:00; however, the item was not readily available in Duncanville and had to be ordered with a delivery date of one (1) week. Respondent states that because it was a special order and a holiday, the device did not arrive until January 8, 2009.
9. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure nursing staff conducted accurate assessments or implemented timely intervention, which included notifying the physician of the conditions of Resident RS and Resident HA, who experienced changes in existing pressure ulcers. Respondent's failure to adequately supervise nursing staff may have contributed to the development of new pressure ulcers and/or the worsening of the existing pressure ulcers.

10. In response to the incident in Finding of Fact Number Nine (9), Respondent states she was constrained by many realities unique to long-term care nursing, and while perfection was not present, there is no evidence that errors or omissions by Respondent contributed to inadequate patient care. Respondent states no specific action by Respondent caused pressure ulcers or if pressure ulcers would have been prevented by perfect care, given the medical conditions of the patients.
11. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure licensed personnel were qualified and knowledgeable in assessing and identifying current or newly developed pressure ulcers for Residents DS and HA, as indicated by the inaccurate skin assessments dated December 23, 2008, December 31, 2008, and January 7, 2009, in the weekly pressure ulcer QI logs. Respondent's conduct failed to adequately supervise nursing staff, which may have deprived the residents of accurate and timely detection of developing pressure ulcers.
12. In response to the incident in Finding of Fact Number Eleven (11), Respondent states staff members were involved in the following in-services prior to the survey resulting in the allegations:
- On May 19, 2008, facility nursing staff members were educated on the use of a wound vac, and on July 2 & 3, 2008, skin assessment issues were discussed during the in-service including head to toe assessments on new admissions, weekly skin assessments, Braden scale use, physician notification parameters with wound response, completion of treatments and wound descriptions.
  - On September 8, 2008, pressure ulcer prevention was the topic of the in-service.
  - On September 18, 2008, another skin in-service was performed with nursing staff that addressed weekly skin assessment documentation.
- After the survey, nursing staff members attended the following in-services:
- On January 14, 2009, skin care was the topic of the in-service.
  - On January 23, 2009, skin care was the topic of the in-service..
  - An extensive in-service on January 30, 31, and February 1, 2009, which covered common pressure ulcer misconceptions, regulation, pressure etiology, staging, obtaining accurate measurements, documentation, pain, best practice recommendations, following infection control procedures, admission care plans and MDS.
13. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure licensed personnel completed care plans for Resident DS that addressed pressure ulcers. Respondent's failure to adequately supervise nursing staff may have contributed to an inaccurate medical record and subsequently delayed assessment and

timely nursing interventions regarding management of pressure ulcers.

14. In response to the incident in Finding of Fact Number Thirteen(13), Respondent states Comprehensive Care Plans were completed on January 14, 2009, which addressed the resident's wounds. The Comprehensive Care Plan is to be completed seven days after the Comprehensive Assessment, which must be done 14 days after admission. The resident's care plan was completed 21 days after admission.
15. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure that licensed personnel had obtained physician orders for treatment of all Resident DS's pressure ulcers, and included them on the January 2009 Treatment Record. Respondent's failure to adequately supervise nursing staff may have contributed an to an incomplete treatment record, which subsequent caregivers would rely on to provide ongoing treatments for the resident's pressure ulcers.
16. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure Certified Nurse Aides and other care staff were reporting the lack of dressings on Resident HA's pressure ulcers to the licensed staff . Respondent's failure to adequately supervise nursing staff may have deprived the licensed staff the information necessary to assess and provide appropriate nursing interventions.
17. In response to the incident in Finding of Fact Number Sixteen (16) Respondent states the Resident was non-compliant with treatment, removed his own dressings, removed positioning pillows and refused to turn and reposition himself, proving detrimental to wound care healing.
18. On or about December 2008, through January 2009, while employed as the Director of Nurses with Duncanville Healthcare and Rehabilitation Center, Duncanville, Texas, Respondent failed to ensure nursing staff had performed weekly skin assessments of Resident HA as evidenced by the lack of assessment sheets in the Treatment Book for January 2009. Respondent's conduct failure to adequately supervise nursing staff may have contributed to an incomplete medical record, which subsequent caregivers would rely on to provide ongoing medical care.
19. In response to the incident in Finding of Fact Number Eighteen (18), Respondent states the facility was newly opened and they did not have a Wound Care Nurse, which accounts for the lack of continuity in assessments.

#### 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)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B)&(1)(U) and 22 TEX. ADMIN. CODE §217.12(1)(B),(2)&(4).
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 728131, and Vocational Nurse License Number 116893, heretofore issued to BARBARA BRYANT MCKINNEY, including revocation of Respondent's licenses to practice nursing in the State of Texas.

### ORDER

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

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order successfully

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

(2) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete a course in "Infection Control," a 5.0 contact hours workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop 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 website:*

<http://www.dads.state.tx.us/providers/Training/jointtraining.cfm> or by contacting (512) 438-2201.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete a course in "Pressure Ulcers," a 4.5 contact hours workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop 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 website:*

<http://www.dads.state.tx.us/providers/Training/jointtraining.cfm> or by contacting (512) 438-2201.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.*

**IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64)**

**HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:**

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

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

(6) RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if

necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

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

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

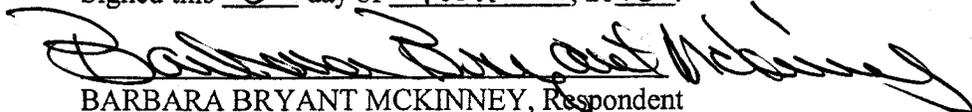
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RESPONDENT'S CERTIFICATION

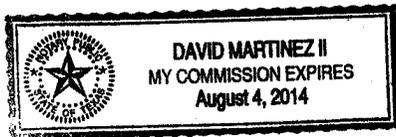
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

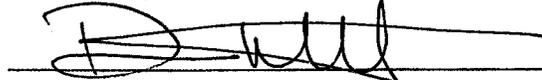
Signed this 3 day of ~~November~~ <sup>3<sup>rd</sup> December</sup>, 2010.

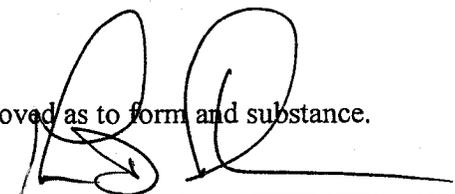
  
BARBARA BRYANT MCKINNEY, Respondent

Sworn to and subscribed before me this 3 day of December, 2010.

SEAL



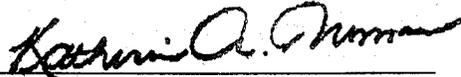
  
Notary Public in and for the State of TX

Approved as to form and substance.  
  
Glen D. Sanborn, Attorney for Respondent

Signed this 8<sup>th</sup> day of DECEMBER, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 3<sup>rd</sup> day of December, 2010, by BARBARA BRYANT MCKINNEY, Registered Nurse License Number 728131, and Vocational Nurse License Number 116893, and said Order is final.

Effective this 27th day of January, 2011.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas".

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