



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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse § AGREED  
License Number 715999, issued to §  
LOVELLA LAURILLA DELAROSA § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of LOVELLA LAURILLA DELAROSA, Registered Nurse License Number 715999, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Sections 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on September 4, 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 representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
- 3. Respondent is currently licensed to practice professional nursing in the State of Texas.
- 4. Respondent received a Baccalaureate Degree in Nursing from Filamer Christian College, Philippines, on March 24, 1994. Respondent was licensed to practice nursing in the State of Texas on June 7, 2005.
- 5. Respondent's nursing employment history includes:

04/95 - 04/97	Staff Nurse	Roxas Memorial Provincial Hospital Roxas City, Capiz
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Respondent's nursing employment history continued:

07/97 - 11/99	Clinical Nurse	Philippine Medical Tests System Quezon City, Philippine
08/00 - 10/00	Staff Nurse	Changi General Hospital Republic of Singapore
05/01 - 01/08	Staff Nurse	Methodist Health System Methodist Dallas Medical Center Dallas, Texas
02/08 - Present	Unknown	

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, and had been in this position for four (4) years and four (4) months.
7. On or about September 24, 2005, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to provide nursing care during her shift to Patient Medical Record Number 00588616, who was assigned to her care. In addition, Respondent failed to administer the patient's Vancomycin at 0400, as ordered by the physician. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that the patient was not getting the care that he may have needed and Respondent's failure to administer medication as ordered by the physician could have resulted in a delay of treatment of his disease process.
8. On or about April 8, 2006, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to administer a sleeping pill to Patient Room Number 6, as ordered by the physician and requested by the patient at 2400. Later Respondent failed to institute appropriate nursing intervention after the respiratory technician reported to her that the patient had an oxygen saturation in the low 80s and had vomited all over himself. Respondent instructed the respiratory technician to clean the patient and she left the room. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to lack of timely interventions, untreated disease processes, and a delay of treatment of the patient's disease process.
9. On or about July 13, 2006, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent left a tourniquet on the arm of Patient Room Number 9017. The tourniquet was removed by the physician who found it on the patient. In addition, Respondent attempted to hang 1/2 Normal Saline on the patient instead of Normal Saline as ordered. The double check nurse caught the error before Respondent initiated the fluids. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to lack of timely interventions, untreated disease processes, and a delay of treatment of the patient's disease process.

10. On or about July 28, 2006, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent took two (2) bottles of radiological contrast to Patient Room Number 9014 for her to drink, instead of one bottle as ordered by the physician. One of the bottles of contrast was clearly labeled for Patient Room Number 9011. The staff nurse assigned to room 9011 was able to retrieve one bottle before the patient in room 9014 drank it; however the patient drank the bottle labeled for the other patient. In addition, Respondent documented that Patient Room Number 9014 left at 1500 when in fact the patient left at 1200. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that administration of radiological contrast in excess of the physician's order could result in the patient suffering from adverse reactions, including nausea and vomiting. Respondent's conduct also resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the accuracy of the information while providing care to the patient.
11. On or about December 24, 2006, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent removed the post surgical back drain for Patient Medical Record Number 00383241 without a physician's order. The order for removal of the drain was for another patient. Respondent's conduct exposed the patient unnecessarily to a risk of harm from a delay in healing and recovery and exposed the patient to infection from removal of the drain without a physician's order.
12. On or about December 27, 2006, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent falsely documented that Patient Medical Record Number 00533654 received pain medication when the patient had not received the medication and the order had been discontinued. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the accuracy of the information while providing care to the patient.
13. On or about August 8, 2007, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to administer Cytotec 200 mcg at 0600 to Patient Medical Record Number 006665729 as ordered by the physician. Respondent failed to ensure that the physician's order was re-written when the patient was transferred from the Labor and Delivery Unit. Respondent's conduct exposed the patient unnecessarily to a risk of harm from a delay of treatment of the patient's disease process.
14. On or about January 2, 2008, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to correctly administer Ampicillin 115mg to Patient Medical Record Number 00682123 as ordered by the physician. Respondent prepared the medication for IM administration; however she administered the medication IV. Respondent falsely documented that the medication had been double checked by a staff member that was not present at the time of the administration. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that administration of Ampicillin using a route not ordered by the physician could result in the patient suffering from adverse reactions or non-efficacious treatment. Respondent's conduct also resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the accuracy of the information while providing care to the patient.

15. On or about January 20, 2008, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to accurately document the weight for Patient Medical Record Number 006833656. Respondent documented 8 lbs 9.6 ozs instead of 5lbs 15ozs which resulted in the patient being discharged without a car seat test to rule out apnea. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes. Respondent's conduct also resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the accuracy of the information while providing care to the patient.
16. On or about January 23, 2008, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to perform incontinent care for Patient Medical Record Number 00673755 after she was informed during change of shift that the patient was incontinent and needed frequent checks. The oncoming shift found the patient in a urine soaked bed with a puddle of urine on the floor. In addition, Respondent failed to document nursing care provided to the patient in the patient's medical record. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that the patient was not getting the care that he may have needed and failure to document was likely to deceive subsequent care givers who relied on the information while providing care to the patient.
17. On or about January 23, 2008, while employed with Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, Respondent failed to accurately document information on the 24-Hour Chart Check. Her documentation reflected the admission on January 22, 2008, at 0050; however the patient was not admitted until January 22, 2008, at 1900. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the accuracy of the information while providing care to the patient.
18. In response to Findings of Fact Numbers Seven (7) through Seventeen (17), Respondent states, that for some of the incidents she was called by her Manager in 9 bedtower Neuro/Surgical/Med-Surg/Ortho Unit for written conferences. She had a problem with the co-workers on the floor. The co-workers had no respect and they did not value her as a team. "If they don't like you, you will not get any support from them." Every time she worked, it seemed like she got the hardest patients and she felt she was always drowning. They always had six (6) of the sickest and very needy patients. Sometimes they did not have aids to help and they were usually short staffed. During her stay, seven nurses left in consecutive months and two nurses got sick and went to another unit. Sometimes they had no patient care technician to take care of the patients' bed and bath in the morning, so it was a heavy load for her. If she's alone she also had to do all the vital signs of patients. She voluntarily resigned from Methodist Health System, Methodist Dallas Medical Center, Dallas, Texas, effective January 30, 2008. Respondent states that she admits some of her errors, but it was already beyond her control. She is only human and subject to commit errors when the environment is not safe anymore. The errors were not intentional.

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)(A),(B),(C),(D),(M),(P) &(3) and 217.12(1)(A),(B),(4),(6),(A)&(H).
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 715999, heretofore issued to LOVELLA LAURILLA DELAROSA, including revocation of Respondent's license 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 REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

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

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

IT IS FURTHER AGREED that:

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

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour

clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*  
*<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>*

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

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

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://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 TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE**

**ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:**

(5) 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.

(6) 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.

(7) For the duration of the stipulation period, 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.

(8) 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 two (2) years of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT 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 waive representation by counsel. 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.

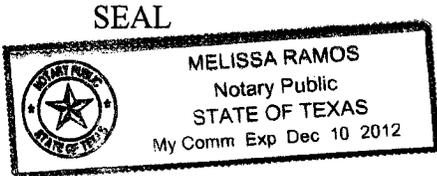
Signed this 24<sup>th</sup> day of October, 20 10.

*Lovella Laurilla Delarosa*       10/4/10

LOVELLA LAURILLA DELAROSA, Respondent

Sworn to and subscribed before me this 4<sup>th</sup> day of October, 20 10.

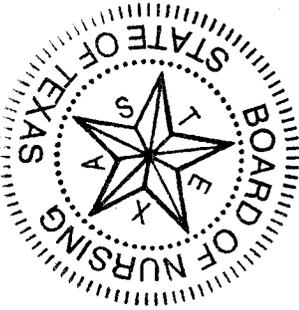
*Melissa Ramos*



Notary Public in and for the State of TEXAS

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 14<sup>th</sup> day of October, 2010, by LOVELLA LAURILLA DELAROSA, Registered Nurse License Number 715999, and said Order is final.

Effective this 9<sup>th</sup> day of November, 2010.



*Katherine A. Thomas*

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