

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Vocational Nurse § AGREED
License Number 92942 §
issued to HELEN A. JEANNITON § ORDER



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Patricia P. Thomas
Executive Director of the Board

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Vocational Nurse License Number 92942, issued to HELEN A. JEANNITON, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c) of the Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, 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.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent's license to practice vocational nursing in the State of Texas is currently in delinquent status.
4. Respondent received a Certificate in Vocational Nursing from Austin Community College, Austin, Texas on September 10, 1981. Respondent was licensed to practice vocational nursing in the State of Texas on December 11, 1981.
5. Respondent's complete vocational nursing employment history is unknown.

6. On or about January 9, 2009, while holding a permanent license as a Vocational Nurse (Delinquent) in the State of Texas and holding Registered Nurse License Number 094000613RN issued by the Oregon State Board of Nursing, Respondent was issued a Suspension of her Oregon Registered Nurses License for sixty (60) days followed by two (2) years of probation for Unprofessional Conduct and Patient Neglect regarding incidents occurring while Respondent was working as a Registered Nurse for the Oregon State Hospital, Salem, Oregon. A copy of the Oregon State Board of Nursing Final Order, Findings of Fact and Conclusions of Law dated January 9, 2009 is attached and incorporated, by reference, as part of this pleading.
7. Charges were filed on March 4, 2010.
8. Charges were mailed to Respondent on March 15, 2010.
9. 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 violation of Texas Occupations Code, Section 301.452(b)(8).
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 92942, heretofore issued to HELEN ANITA JEANNITON, 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 92942, heretofore issued to HELEN ANITA JEANNITON, 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 waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation 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 16th day of June, 2010.

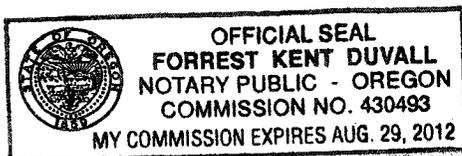
Helen Anita Jeanniton
HELEN ANITA JEANNITON, Respondent

Sworn to and subscribed before me this 16 day of June, 2010.

SEAL

Forrest Kent Duvall

Notary Public in and for the State of OREGON



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 92942, previously issued to HELEN ANITA JEANNITON.



Effective this 25th day of June, 2010.

A handwritten signature in black ink, which appears to read 'Katherine A. Thomas'.

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

BEFORE THE
OREGON
STATE BOARD OF NURSING

DATE: 1-15-09
I certify this to be a true copy of the records on
file with the Oregon State Board of Nursing.
SIGNED: Pat Hammer

IN THE MATTER OF:

HELEN JEANNITON, RN
License No. 094000613RN

) **FINAL ORDER**
)
) OAH Case No.: 800471
) Agency Case No.: 07-134

HISTORY OF THE CASE

On March 10, 2008, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Disciplinary Action against Registered Nurse License (Suspension Followed by Probation) regarding the Registered Nurse (RN) license of Helen Jeanniton (Licensee). On March 17, 2008, Licensee requested a hearing.

On March 17, 2008, the Board referred the hearing request to the Office of Administrative Hearings (OAH). Administrative Law Judge (ALJ) Robert L. Goss was assigned to preside at hearing. A telephone prehearing conference was convened on June 25, 2008. Licensee appeared through counsel, Thomas K. Doyle. The Board appeared through Assistant Attorney General Joanna Tucker Davis.

A hearing was held on October 14 and 15, 2008, in Tualatin, Oregon. Licensee appeared with counsel (Thomas K. Doyle) and testified. No other witnesses testified on behalf of Licensee. The Board was represented by Assistant Attorney General Joanna Tucker Davis. Michelle Standridge appeared as the authorized representative of the Board. Testifying on behalf of the Board were Licensee, Michelle Standridge, RN June Lawson, RN Alfredo Basto, RN Angelika Schmoll, Richard Yates, Judy Hoke, CMA Jeff Heltsley, RN Lori Kessler, RN Lori Martin, Lorinda Edwards and Travis Richards. The record remained open after the hearing for the receipt of written closing arguments and closed on November 14, 2008.

On December 17, 2008, ALJ Robert L. Goss issued a proposed order in this matter. The proposed order notified Respondent of her right to file exceptions within 10 days of service. Respondent did not file any exceptions.

In accordance with ORS 183.650(2) and -(3), and OAR 137-003-0665(3) and -(4), the Board must identify and explain those modifications to proposed findings of historical fact that change the outcome or basis for this Final Order from those in the proposed order. The Board has not made any changes that substantially modify the ALJ's proposed findings of historical fact. The Board has made other changes to fully, adequately or correctly set forth the material evidence in the record, to clarify, correct or amend the findings of the ALJ, and to explain the Board's

findings, conclusions, and opinion herein. The Board has also made changes to correct spelling, grammar, textual placement, and other similar errors.

ISSUES

1. Whether Licensee, on or about July 30, 2003 engaged in unprofessional behavior, in violation of the standard of nursing practice/care under ORS 678.111(1) (f) and (g) and OAR 851-045-0015(2)(j) and (9).
2. Whether, Licensee, on or about October 22, 2003, discovered and failed to properly report a medication error, in violation of the standards of nursing practice/care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a); (3)(a), (b), (g) and (h); and (4)(b).
3. Whether Licensee on or about October 28, 2003, failed to communicate her location to co-workers, and as a result, Licensee failed to meet the standards of nursing practice and care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a); (3)(h) and (4)(b).
4. Whether Licensee, on or about November 9, 2004, engaged in an inappropriate interaction with a patient which resulted in the patient becoming agitated, in violation of the standards of nursing practice and care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a), (b), (d) and (l); (2)(a), (b) and (c) and (4)(b).
5. Whether Licensee, on or about January 12, 2005, after discussing staffing concerns with supervisors, left the facility for the remainder of her shift, in violation of the standards of nursing practice and care under ORS 678.111(1) and (g) and OAR 851-045-0015(1) (a), (i) and (j); (3)(h) and (4)(b).
6. Whether Licensee, on or about May 3, 2005, did not respond to staff's calls for a show of concern (SOC) and was found in a medication room with both doors closed, in violation of the standards of nursing practice and care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a), (b) and (j); (2)(b); (3)(h) and (4)(b).
7. Whether the above conduct, if proved, was conduct derogatory to the standards of nursing or a violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder. ORS 678.111(1)(f) and (g) and OAR 851-045-0015(1) (a), (b), (c), (d), (i), (j) and (l); (2)(a), (b), (c) and (j); (3)(a), (b), (g) and (h); (4)(b) and (9).
8. If so, whether a 60 day suspension of Licensee's license and a subsequent 24 month probationary period is an appropriate sanction.

EVIDENTIARY RULING

Exhibits A1 through A28, offered by the Board, were admitted into the record, with the exception of Exhibit A5, which was withdrawn by the Board. No exhibits were offered by Licensee.

FINDINGS OF FACT

1. Licensee was employed as a licensed RN at the Oregon State Hospital (OSH) in Salem from February 1998 until October 2006. Licensee's duties included maintaining awareness of patient conditions and environmental status, providing for competent administration of medications, providing routine nursing care and specialized nursing tasks, as well as fulfilling all RN documentation requirements, including assessments to evaluate patient's functional abilities, disabilities and nursing needs. (Test. of Licensee; Exhibits A7, A23.)

2. OSH uses a team based therapeutic model, meaning that the various members of a patient's treatment team, including the assigned RN and other medical and mental health professionals form what is called the Interdisciplinary Team (IDT). The members of the IDT provide input on the patient's treatment care plan and meet with the patient at an IDT meeting.

At those meetings, the IDT first discusses the patient's needs and care plan, then the patient is brought into the meeting and included in the discussion. Proper care to the patient requires that the IDT effectively communicate with each other and with the patient. (Test. of Yates and Martin.)

3. On July 30, 2003, Licensee was assigned to the Forensic Rehabilitation and Treatment Services Program on Unit 41B of OSH. On that date, Licensee attended an IDT meeting regarding an African-American patient assigned to a co-worker, Terry Miller. Licensee is also African-American. At that meeting, Licensee became angry and raised her voice, pointed her finger and accused Mr. Miller of being racist. Licensee believed Mr. Miller was racist due to an incident where Miller had disregarded Licensee's instructions to help a patient. Licensee did not report that incident to anyone at OSH prior to the July 30, 2003 meeting. After Licensee's accusation, the other IDT members attempted to redirect Licensee to the patient's treatment care plan but Licensee would not do so. Licensee continued to accuse Miller of racism and of being an inappropriate case monitor because he was a white male. The IDT was not able to continue the discussion about the patient's care plan due to Licensee's statements and behavior. The meeting was adjourned before the patient could be brought in because the atmosphere of the meeting was no longer beneficial to the patient. (Exhibits A3, A4, A7; Test. of Yates and Licensee.)

4. On October 22, 2003, Licensee was the swing shift ward nurse on Ward 41B. CMA Jeff Heltsley, the medication aide on duty on the ward during that shift, reported to Licensee that he had found 15 unaccounted for prescription pills in a patient's Lac-Dose container. Lac-Dose is a non-prescription medication for lactose intolerance. CMA Heltsley showed the pills to Licensee and asked that Licensee lock them up in the narcotic box. Licensee identified the pills and the patient they were meant for, placed them in a plastic bag with a list of the pills and locked them in the narcotics box. Licensee gave a brief description of the incident to the night shift nurse before leaving. The night shift nurse assumed that the patient had hoarded the pills in his room and told the subsequent day shift nurse that the pills were found in the patient's room. Because it was believed that the patient had been hoarding the pills in his room, the day shift nurse placed the patient on a "daily screening hold" during which the patient could not leave the unit and go to work. RN Angelika Schmoll investigated the incident and discovered that Licensee had not provided any written documentation of the incident. Licensee failed to

complete a medication incident report; failed to make entries in the RN chart notes and failed to document the incident in the 24 hour nursing report. (Exhibit A9; Test. of Schmoll, Heltsley and Martin.)

5. On October 28, 2003, Licensee was working on Unit 41B. On that date, Licensee failed to communicate with her co-workers about her location when she was scheduled to cover for breaks and lunch periods. Alfred Basto, RN, went looking for Licensee and subsequently found Licensee in an office, with the door closed, the lights out, using a computer to view the internet. RN Basto was told by the CNAs and CMAs working under Licensee's supervision that she often sat in a locked office. (Exhibit A9; Test. of Basto and Licensee.)

6. OSH's standard practice is to keep doors open when located in an office, so as to be able to hear what is going on in the unit. Licensee sometimes would go into a locked office during her shift during "down time". Licensee believed she could have heard yelling on the ward while isolated in the room, but also stated that she would have difficulty hearing occurrences down the hall. (Exhibit A9; Test. of Basto and Licensee.)

7. On November 9, 2004, Licensee was assigned to Ward 35C as the mental health RN. At around 7:45 p.m., Licensee gave CG his scheduled medications. CG then asked Licensee for his PRN (provided as needed) medication. Licensee told CG that he should return later at 8:00 p.m. At 8:00 p.m., CG returned and again asked for his PRN medication. There were no other patients in the area at the time. Licensee told CG that she first needed to take care of the other patients' medication. CG became agitated, noted to Licensee that there were no other patients in the area and said he would leave if he was given his PRN medication. Licensee engaged with CG in a verbal dispute about when Licensee would give CG his medication. Licensee's voice was raised during this dispute and at one point she yelled in CG's presence "Get this patient out of my face now". CG became even more agitated, left the area without his medication, causing damage to a water fountain that he kicked as he left. (Exhibits A15, A16; Test. of Richard and Licensee.)

8. On December 27, 2004, Licensee was assigned patient WJ as part of a patient re-assignment due to another staff member being off on a long term basis. Licensee received a copy of that assignment in her box that day, and the re-assignment was also clearly noted on a large white board in the medication room where Licensee could clearly see it. At OSH, when a nurse is assigned a patient, the nurse has a duty to ensure that the patient's medical needs are met and to create monthly nursing summaries on the patient. The monthly summaries are used at the patient's IDT meetings, which occur either every month or every other month, depending on the patient's status. A few days later, Licensee went to her supervisor, RN Lori Kessler, who had assigned the patient to Licensee, and told her that she did not want the assignment, stating that she had too many patients assigned to her. The usual patient load for nurses and other staff members was four to five patients. The addition of patient WJ increased Licensee's load to five patients. RN Kessler told Licensee at that initial meeting that the assignment of patient WJ would remain in effect. In early March, 2005, RN Kessler was reviewing the patient charts and discovered that Licensee had not prepared any case summaries on patient WJ since the patient had been assigned to Licensee. RN Kessler discussed this with Licensee and was told again that Licensee refused to accept the assignment. On March 10, 2005, LK issued to Licensee a letter of

expectation informing her that her duties included writing both progress notes and nursing summaries for patient WJ. Licensee continued to fail to complete nursing summaries through April 2005. (Exhibits A14, A17, A18, A19, A21; Test. of Kessler.)

9. On January 12, 2005, Licensee arrived to start her scheduled swing shift. Licensee met with her supervisor to discuss Licensee's concerns about the staffing needs of the ward, specifically the fact that there was no medication aide for that shift. Licensee was told by her supervisor that the current staffing levels met all requirements and that her request for a medication aide could not be accommodated. Licensee later spoke to RN Kessler, informed her that she was upset and wanted to go home. RN Kessler told Licensee that there were no other staff members available to replace her and suggested that Licensee take a walk to compose herself and then return to work. Licensee left the ward and initially went to the Human Resources office and spoke with Lorinda Edwards. In that ensuing discussion, Ms. Edwards told Licensee that she should return to work, but that if she could not, she should contact her supervisor. Licensee went back to her assigned unit, but did not contact her supervisor. Licensee left a message with a ward staffing clerk, and informed her that she was ill and that she was leaving for the remainder of the day. LK, Licensee's supervisor, was on duty at the time. Licensee did not contact her supervisor or make any other arrangements for coverage for her patients. Later, when asked about the incident, Licensee told Human Resource staff persons that when she was in Ms. Edward's office, Ms. Edwards agreed that Licensee was unable to continue with her shift and that Licensee called the staffing clerk to tell her that she was leaving work, with Ms. Edward's knowledge. That statement was false. (Exhibits A20, A21, A23; Test. of Kessler, Edwards and Licensee.)

10. On May 3, 2005, Licensee was assigned to Ward 35C as one of the ward nurses. When a co-worker went on a lunch break, it was Licensee's responsibility to cover the ward and to be available to respond to any incidents involving patients. During this time, the patient CG, known to have a history of violent attacks against others, displayed extreme behavior, resulting in a "show of concern" (SOC) being called in by two CNAs. Licensee did not respond to the calls for help, so the staff hit the panic buttons causing a building wide alarm. Licensee still did not respond. When a supervising RN June Lawson went to the ward in response to the alarms, she found Licensee inside a medication room with both doors closed. Later in the same shift, another SOC occurred involving patient CG and Licensee again was found in the medication room with both doors closed. (Exhibit A23; Test. of Lawson and Hoke.)

11. The Board, in proposing this sanction against Licensee, took into account the seriousness of the violations, the fact that Licensee did not seem to understand the gravity of the violations, along with Licensee's experience as an RN and the lack of any prior disciplinary history with the Board. (Test. of Standridge.)

CONCLUSIONS OF LAW

1. Licensee, on or about July 30, 2003 engaged in unprofessional behavior, in violation of ORS 678.111(f) and (g) and OAR 851-045-0015(2)(j) and (9).

2. Licensee, on or about October 22, 2003, discovered and failed to properly report a medication error, in violation of the standards of nursing practice/care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a); (3)(a), (b), (g) and (h); and (4)(b).

3. Licensee, on or about October 28, 2003, failed to communicate her location to co-workers, and as a result, failed to meet the standards of nursing practice/care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a); (3)(h) and (4)(b).

4. Licensee, on or about November 9, 2004, engaged in an inappropriate interaction with a patient which resulted in the patient becoming agitated, in violation of the standards of nursing practice/care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a), (b), (d) and (l); (2)(a), (b) and (c) and (4)(b).

5. Licensee, on or about January 12, 2005, after discussing staffing concerns with supervisors, left the facility for the remainder of her shift, in violation of the standards of nursing practice/care under ORS 678.111(1) and (g) and OAR 851-045-0015(1) (a), (i) and (j); (3)(h) and (4)(b).

6. Licensee, on or about May 3, 2005, did not respond to staff's calls for a show of concern (SOC) and was found in a medication room with both doors closed, in violation of the standards of nursing practice/care under ORS 678.111(f) and (g) and OAR 851-045-0015(1) (a), (b) and (j); (2)(b); (3)(h) and (4)(b).

7. The above conduct was conduct derogatory to the standards of nursing or a violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder. ORS 678.111(1)(f) and (g) and OAR 851-045-0015(1) (a), (b), (c), (d), (i), (j) and (l); (2)(a), (b), (c) and (j); (3)(a), (b), (g) and (h); (4)(b) and (9).

8. A 60 day suspension of Licensee's license and a subsequent 24 month probationary period is an appropriate sanction.

OPINION

Jurisdiction of this matter lies with the Board. ORS 678.111. The Board bears the burden of proving by a preponderance of the evidence that a suspension of Licensee's license and imposition of a subsequent period of probation is warranted. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Metcalf v. AFSD*, 65 Or App 761, 765(1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractors v. Tandy Corp*, 303 Or 390, 402 (1987).

The Board has proposed suspending Licensee's registered nurse license and imposing a subsequent period of probation under ORS 678.111(1)(f) and (g) which provides, in relevant part:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

* * *

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provisions of ORS 678.010 to 678.445 or rules adopted thereunder.

Seven separate incidences of conduct which warrant the suspension and probation are at issue here. Each incident is addressed separately below. Each incident cites violations of one particular rule that both parties agree was in effect at the time of these incidences (OAR 851-045-0015). For clarity and brevity, the relevant portions of the Board rule are cited in the following endnote¹.

1. Events of July 30, 2003 (IDT meeting).

Licensee committed conduct derogatory to the standards of nursing by abusing a co-worker at an IDT meeting, adversely affecting a patient's care, thereby violating ORS 678.111(f) and (g) and OAR 851-045-0015(2)(j) and (9). Those rule subsections provide that nurses must practice without discrimination on the basis of race and refrain from abusive behavior to a co-worker which relates delivery of safe care to a patient. Licensee inappropriately confronted case monitor Terry Miller, pointing her finger at him, becoming angry, raising her voice and calling him a racist. Other than denying that she raised her voice, Licensee does not substantively contradict the Board's evidence. The ALJ found, and the board concurs, that Licensee did raise her voice in this incident.

Licensee contends that her statement to Mr. Miller that he was racist was not discriminatory, but rather merely raising a concern of discrimination against the patient and the racial aspect to the patient's care. However, Licensee's statement was a clear accusation of racism on the part of Mr. Miller, based on one prior incident where Mr. Miller did not follow her instructions. The single prior incident such as this one cannot reasonably support a belief that a person is racist. Licensee did not offer any other objective facts that would justify her belief that Mr. Miller was racist. The statement was discriminatory and adversely affected the patient care, as the meeting came to an almost immediate halt at that point and the patient was not able to take part in the meeting as scheduled. Also noteworthy is that before this IDT meeting, Licensee had other, more appropriate avenues to report her concern about Mr. Miller's alleged racism, but she did not report her concern to anyone before the meeting. As a reasonable and prudent employee

and RN, Licensee more appropriately could have chose to raise her concerns at the IDT meeting in a way other than the inflammatory fashion she chose.

Licensee's statements constituted "abuse" of Mr. Miller as defined in *Webster's Third New International Dictionary (unabridged 2002)* at 8 as "language that condemns or vilifies usu. unjustly, intemperately, and angrily". Licensee accused Mr. Miller of a trait that would have serious consequences in his career and his personal relations. That behavior also adversely affected the patient's care, in that the statements and behavior shut down the care meeting, ending any further discussion of the patient and prevented the patient from attending the meeting.

Events of October 22, 2003 (15 unaccounted for pills)

Licensee failed to properly account for and communicate about 15 unidentified pills found in a patient's medicine container, violating ORS 678.111(1)(f) and (g) and OAR 851-045-0015(1)(a); (3)(a), (b), (g) and (h) and (4)(b). The rule defines conduct derogatory to the standards of nursing as including the obligation to keep accurate, complete and timely records, communicate information regarding a client's status in an accurate manner, to refrain from unsafe nursing practices and to conform to essential standards of acceptable and prevailing nursing practice.

As described more fully in Finding #4 above, Licensee was informed from a CMA that he had discovered 15 unaccounted for pills in a patient's Lac-Dose container. The pills were prescription medications. Licensee identified the pills, placed them in a bag with a list of the pills and locked them in the narcotics box. Licensee later gave a brief oral description of the incident to the next shift's nurse. That nurse assumed from Licensee's statement that the patient had hoarded the pills in his room and told the next shift's nurse that the pills had been found in the patient's room. Licensee's failure to properly document the incident led to the patient being wrongfully denied the ability to go to work that day.

Licensee did not contradict the Board's evidence on this subject, other than her testimony that she believed she had created a medication incident report. Licensee could not provide any details or supporting evidence to support her testimony.

Licensee failed to create any written documentation of the discovery of the unaccounted for pills and that is a direct violation of the cited rule. Licensee's contention that no medication error actually occurred is not persuasive. Any unaccounted for medications, in this case medications found in the wrong place, can reasonably be deemed an error. Medications provided for the benefit of patients at the OSH must be highly controlled, for a myriad of reasons, including the safety of patients. Any lapse in the control of those medications must be taken seriously and proper documentation of such errors are important to understand the reasons for such errors and to minimize such occurrences in the future.

Licensee's incomplete documentation resulted in an unclear and confusing situation. Without having the full picture of the incident, through either a complete verbal report or the required written report, the next shift's nurse incorrectly assumed that the patient had been

hoarding medication in his room. This error eventually caused the patient to lose a day of work. Licensee's failure to fully and accurately report the medication incident adversely affected that patient's care. Licensee's argument that there was simply a miscommunication with the next shift's nurse misses the point. Licensee should have properly documented the medication error through the required reports. If she had, no such "miscommunication" would have occurred.

3. Events of October 28, 2003 (Unable to locate Licensee during her shift).

Licensee failed to properly communicate with other co-workers on her shift concerning her whereabouts, in violation of ORS 678.11(1)(f) and (g) and OAR 851-045-0015(1) (a); (3)(h) and (4)(b). Those parts of the rule describe conduct derogatory to the standards of nursing as including conduct relating to a client's safety and integrity, using nursing practices which jeopardize client safety, failing to communicate information with members of the health care team and failing to conform to standards of acceptable and prevailing nursing practice.

Licensee, on that date, while on duty, went into a closed room without informing the shift staff as to her whereabouts. This caused another staff member, RN Basto, to have to search for her. Licensee also testified that she would go into the nurse's room or the medication room, with the door closed on a regular basis during "down time."

By isolating herself from the rest of the ward and staff, Licensee did not meet her responsibility to properly supervise the patients and staff working under her license. RN Basto and RN Martin both testified that this is a dangerous practice which does not conform to the acceptable standards of nursing.

Licensee's attempts to minimize the effect of her isolation are not persuasive. Although she testified that she could hear if someone was yelling, she also testified that she would have difficulty hearing something down the hall. Also, there could be many instances of issues occurring on the ward that would require Licensee's response, short of crisis or emergency issues where someone might have to yell to get Licensee's attention. This could include being aware of situations that can be de-escalated and averted before an emergency or other crisis arises. Licensee also testified that she could be found if the staff looked for her. This argument misses the point. Licensee is the one who bears the responsibility of exercising proper nursing judgment. The other staff members on the ward on Licensee's shift work under her license and they are not responsible for exercising proper nursing judgment. Licensee can exercise that judgment only if she maintains an awareness of what is going on in the ward. When Licensee removed herself from the visual and audible occurrences on the ward, she forced the other staff members to supervise the medical care on the ward and therefore abrogated her nursing responsibilities.

Licensee's testimony that other nurses do the same thing and that the door to the room where she was found would shut automatically are not supported by any other evidence in the record.

4. Events of November 9, 2004 (Patient CG and the PRN medications).

Licensee mishandled a contact with a patient (CG) that involved CG's continued request for a PRN medication, thereby violating ORS 678.111(1)(f) and (g) and OAR 851-045-0015(1)(a), (b), (d) and (l); (2)(a), (b), (c); and (4)(b). Those rule subsections describe conduct derogatory to the standards of nursing. That conduct includes conduct relating to a client's safety and integrity, using nursing practices which jeopardize client safety, failing to take action to promote the client's safety based on nursing assessment and judgment, abusing and neglecting clients, and failing to conform to standards of acceptable and prevailing nursing practice.

Licensee's conduct with patient CG on November 9, 2004 was conduct derogatory to the standards of nursing. When Licensee failed to provide CD's PRN medication upon request, her actions resulted in a delay in his medication and CG's increased agitation. In addition, Licensee engaged in a verbal dispute with CG, where she raised her voice and issued inappropriate directives towards CG.

Licensee's behavior in this incident failed to conform to the standards of nursing in four ways. First, Licensee did not attempt to de-escalate patient CG's agitation by assessing then meeting his clinical needs. Second, Licensee, by arguing with patient CG, increased his agitation, for no therapeutic reason. Third, Licensee improperly placed patient CG's need for the PRN medication below her need for convenience. Lastly, Licensee, by yelling "Get this patient out of my face" escalated the situation without any benefit to the patient. Before this incident, OSH had provided Licensee with training in how to de-escalate a situation involving an agitated patient. Licensee admitted that her behavior in this incident did not conform with her training.

Licensee's behavior also neglected patient CG by not providing appropriate nursing care, failing to provide him with appropriate medication and failing to use her nursing judgment and training to properly de-escalate the situation.

Licensee's behavior also abused patient CG. Licensee argued with patient CG, only because it would be inconvenient for her to give patient CG the medication at that time. Licensee's statement of "Get this patient out of my face" was not so much a request for assistance as an expression of Licensee's anger and frustration. As such, the statement meets the definition of patient abuse as defined in OAR 851-045-0015(2) (a), which includes, but is not limited to, intentionally threatening or intimidating a client.

5. Events of December 27, 2004 to April 2005 (Ignoring a patient assignment).

Licensee, although being informed of an assignment of a patient (WJ) on December 27, 2004, and being informed a few days later that the assignment would not be changed, failed to complete the required nursing assessments regarding that patient up through March 2005, in violation of ORS 678.111(1) (f) and (g) and OAR 851-045-0015(1) (a), (b), (c) and (d); (2) (b); (3) (a), (b), (g); and (4)(b). Conduct derogatory to the standards of nursing includes conduct relating to client safety and integrity, using nursing practices which jeopardize client safety, failing to take action to promote the client's safety based on nursing judgment, failing to follow through, or modify as needed, a plan of care, failing to keep proper recordkeeping neglect of a client, and failing to conform to standards of acceptable and prevailing nursing practice.

At the end of December 2004, patient LK was assigned to Licensee both through a notification in her box and in writing on a large whiteboard posted where all staff persons could see it. The assignment remained on the board through April 2005. In January 2005, Licensee told her supervisor, RN Kessler, that she would not take the assignment because she believed the assignment was unfair. RN Kessler told Licensee that she had to take the assignment as part of her job. RN Kessler also credibly testified that adding WJ to Licensee's patient responsibilities did not create an unreasonable case load. In any event, Licensee continued to fail to perform her assigned duties related to patient WJ, including not filling out a monthly nursing summary on his care. Licensee testified that she did keep a chart during that time, but could not say when and could provide no other evidence of such a chart. During the investigation of the incident, Licensee told the investigator that RN Kessler had written a letter stating that Licensee did not have to do nursing summaries for this patient. Licensee could not produce the letter and did not testify to it at hearing. There is no corroborating evidence in the record regarding Licensee's allegations and Licensee has not proven that she kept any records regarding patient WJ or that she was not required to do so. By failing to keep any records regarding patient WJ, Licensee violated the requirement that nurses keep timely and accurate records. Licensee's repeated refusal to take on the assignment of the patient to her care was also a failure to provide or follow through with a plan of care for the patient. Providing no care to an assigned patient adversely affects that patient's safety and integrity.

6. Events of January 12, 2005 (Leaving work after the start of shift).

Licensee left her work shift without properly notifying her supervisor or otherwise insuring that her patient's would be covered in her absence, in violation of ORS 678.111(1) (f) and (g) and OAR 851-045-0015 (1) (a), (i) and (j); (3) (h) and (4) (b). The above rules, specifically (1) (i) and (j), do not prohibit a nurse from leaving an assignment, but it does impose two conditions. First, the nurse must notify the appropriate supervisory personnel and second, the nurse must confirm that nursing care for patients be continued and that nursing responsibilities will be met.

Licensee was upset at the beginning of her shift when she learned that there would be no medication aide assigned to the shift. This had been an ongoing issue with Licensee. She was aware that medication aides were not required as part of staffing and that there would be times when one was not available. On this occasion, Licensee spoke with her supervisor, RN Kessler, who told her to calm down, go for a walk and then return to work. Licensee subsequently left a voicemail for RN Kessler informing her that she was going home, and did so. Licensee did not contact her supervisor in person. Licensee left work without taking proper steps to ensure that her patients would be cared for. Those proper steps could have included informing her supervisor that she was leaving, ensuring that there would be coverage for her patients and giving a status report to a nurse who could assume her responsibilities.

Licensee's defense was that she was very upset at the lack staffing on her shift, making her unable to safely provide patient care. However, as pointed out above, this had been an ongoing issue with Licensee and she was aware that OSH policy was not to require a medication aide as part of staffing requirements. Licensee disagreed with the policy, but understood that this

meant that there would not always be a medication aide assigned to a shift. Licensee, as a nursing professional, had a responsibility to see to it that the care of her patients would not be affected by her inability to work. Licensee failed to properly exercise that responsibility.

7. Events of May 3, 2005 (Unable to locate Licensee during her shift).

On May 3, 2005, Licensee isolated herself during her shift, allowing two separate "show of concern" (SOC)s to occur without her being available to respond. Licensee's conduct, similar to that of October 28, 2003, resulted in violations of ORS 678.111(1) (f) and (g) and OAR 851-045-0015(1) (a), (b), (j); (3) (h) and (4) (b).

On May 3, 2005, Licensee did not respond to a show of concern that was called by two CNAs on Licensee's ward. Having received no response, the CNAs hit the panic button causing a building wide alarm. Licensee still did not respond. A supervising RN later found Licensee inside a medication room with the doors closed.

Licensee's behavior in this incident raises the same issue addressed in section three of this Order. Licensee had a duty and responsibility to be available to respond to the needs of the ward, which she could not reasonably meet by withdrawing into a room with the doors closed. Licensee adversely affected the safety of the patients on the ward and the staff. Licensee's behavior, a continuation of earlier similar behavior, also exhibits a pattern of unacceptable nursing practice.

Penalty

The Board orders a 60 day suspension of her registered nurse license and a subsequent period of probation of 24 months. The sanctions are within the authority of the Board, under ORS 678.111(1). The Board has balanced the serious nature of the violations and Licensee's apparent lack of understanding of the seriousness of those violations with her experience as an RN and the lack of any prior disciplinary history. The penalty is consistent with other similarly situated nurses that have been sanctioned by the Board. The length of the suspension is appropriate, as well as the length of the probationary period, given Licensee's lack of insight as to the seriousness of the violations. A probationary period, with the conditions (other than the particular dates initially described) hereby ordered by the Board, will assist Licensee in recognizing areas of nursing practice that she needs to work on and allow the Board to adequately monitor Licensee's progress in learning proper nursing practices. This penalty is reasonable and consistent with the Board's interest in protecting the health, safety and welfare of patients.

The conditions of probation are as follows:¹

1. Probation shall be for a period of twenty four months. For the purposes of this Stipulation for Probation, the term "month," as used in this subsection, means a

¹ The dates on the conditions of these probations have been modified from the ALJ's proposed order as the dates listed on the proposed order were no longer valid or practical.

calendar month in which you perform the duties of a registered nurse in the State of Oregon a minimum of eighty (80) paid hours.

2. You shall not violate the Nurse Practice Act (ORS 678) or any of the administrative rules adopted thereunder.
3. You shall notify the Board, in writing, prior to any change of address or employment during the probation period.
4. You shall report to designated Board staff once per month for the first six (6) months of the probationary period. Such reports shall be made in person at the Board's offices in Portland, OR, although telephone interviews may be substituted for personal interviews at the discretion of the Board.
5. You shall inform current and prospective employers of the probationary status of your nursing license, the reasons for probation and the terms and conditions of probation. Current and prospective employers are to receive copies of your probationary agreement, and the Final Order adopting it.
6. You shall be employed only in settings approved by the Board where you are directly supervised by a registered nurse and where your nursing supervisor agrees to conduct monthly chart audits which will consist of pulling a minimum of six patient charts to check for errors in the assessment of the client, administration of medication and documentation. Audit results shall be included in the monthly reports to the Board, along with documentation of any related discipline or corrective action.
7. You shall not be employed by a temporary staffing agency during the probationary period unless such assignments are for a period of six weeks or longer.
8. You shall be financially responsible for any costs you may incur as a result of compliance with the terms and conditions of the Board's order.
9. You shall cooperate fully with the Board in the supervision and investigation of your compliance with the terms and conditions of your Probation.
10. You shall complete a course on culturally competent nursing care. You shall provide documentation of your successful completion of the course, no later than June 1, 2009.
11. You shall complete a paper of no less than four (4) pages in length written in APA format on providing culturally competent care in the nursing profession. You shall use peer-reviewed nursing journals dated no later than January, 2005 as sources for this paper. You shall complete and submit the paper to Board staff no later than June 1, 2009.

12. You shall complete a course on professional accountability no later than June 1, 2009. You shall provide documentation of your successful completion of the course to the Board (certificate of completion, transcripts, etc).
13. You shall review division 45 of the Nurse Practice Act regarding the Registered Nurse scope of practice and write a paper a minimum of three (3) pages in length, written in APA format, describing the responsibility of the Registered Nurse to practice within these rules, and how you will implement this in your current practice. The paper shall be completed no later than June 1, 2009.

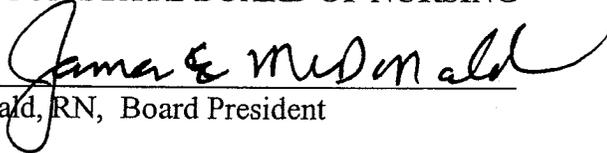
ORDER

The Board issues the following order:

Helen Jeanniton's registered nurse license is suspended for a period of 60 days, followed by a period of probation of not less than 24 months; and to continue until such time as Ms. Jeanniton completes the required terms and conditions of her probation.

Dated this 9th day of January 2009.

FOR THE OREGON STATE BOARD OF NURSING


James E. McDonald, RN, Board President

APPEAL RIGHTS

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board within 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within 60 days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals.

APPENDIX A LIST OF EXHIBITS CITED

- Ex. A3: Questions and meeting notes of Angelika Schmoll dated 7/10/03.
- Ex. A4: Meeting notes of Angelika Schmoll dated 8/14/03.
- Ex. A7: Letter to Licensee from OSH dated 10/22/03.
- Ex. A9: Interoffice Memorandum to Lorinda Edwards from Angelika Schmoll dated 11/13/03.
- Ex. A14: Nursing Staff Assignments for Ward 35C dated 12/27/04.
- Ex. A15: Investigation Report dated 1/04/05.
- Ex. A16: Superintendent's Report on Allegation of Patient Abuse dated 1/18/05.
- Ex. A17: Licensee calendar entries dated 1/21/05-1/25/05.
- Ex. A18: Letter to Licensee from Lori Kessler dated 3/10/05.
- Ex. A19: Email from Lori Kessler to Judy Hoke dated 3/23/05.
- Ex. A21: Notes from OSH Investigatory Interview of Licensee dated 7/29/05.
- Ex. A23: Letter to Licensee from OSH dated 8/17/05.

Conduct Derogatory to the Standards of Nursing Defined

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

- (1) Conduct related to the client's safety and integrity:
 - (a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.
 - (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.
 - (c) Failing to develop, implement and/or follow through with the plan of care.
 - (d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.

* * * *

- (i) Leaving a client care assignment during the previously agreed upon work time period without notifying the appropriate supervisory personnel and confirming that nursing care for the client(s) will be continued.
- (j) Leaving any nursing assignment, including a supervisory assignment, without notifying the appropriate personnel and confirming that nursing assignment responsibilities will be met.

* * * *

- (l) Failing to respect the dignity and rights of clients, regardless of social or economic status, age, race, religion, sex, sexual preference, national origin, nature of health problems, or disability.

* * * *

(2) Conduct related to other federal or state statute/rule violations:

- (a) Abusing a client. The definition of abuse includes, but is not limited to, intentionally causing physical harm or discomfort, striking a client, intimidating, threatening or harassing a client.
- (b) Neglecting a client. The definition of neglect includes but is not limited to carelessly allowing a client to be in physical discomfort or be injured.
- (c) Engaging in other unacceptable behavior towards or in the presence of a client such as using derogatory names or gestures or profane language.

* * * *

(j) Failing to conduct practice without discrimination on the basis of age, race, religion, sex, sexual preference, national origin, nature of health problems or disability.

* * * *

(3) Conduct related to communication:

(a) Inaccurate recordkeeping in client or agency records.

(b) Incomplete recordkeeping regarding client care; including but not limited to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

* * * *

(g) Failing to maintain client records in a timely manner which accurately reflects management of client care, including failure to make a late entry within a reasonable time period.

(h) Failing to communicate information regarding the client's status to members of the health care team (physician, nurse practitioner, nursing supervisor, nurse co-worker) in an ongoing and timely manner.

* * * *

(4) Conduct related to achieving and maintaining clinical competency:

* * * *

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

* * * *

(9) Conduct related to co workers: Violent, abusive or threatening behavior towards a co- worker which either occurs in the presence of clients or otherwise relates to the delivery of safe care to clients.