

Missouri



STATE BOARD OF NURSING NEWSLETTER



The Official Publication of the Missouri State Board of Nursing with a quarterly circulation of approximately 114,000 to all RNs and LPNs

Volume 10 • No. 4

November, December 2008, January 2009

Message from the President

Amanda Skaggs, RNC, WHNP, President



Skaggs

One of the hallmarks of the nursing profession is serving those in need. We accomplish this by helping individuals or families recover their health, maintain health or prevent ominous consequences. The mission of the Board of Nursing echoes these same concepts. Our duty is to serve those in need, the people of the state of Missouri, by ensuring that nurses practicing in this state are competent and by developing policies that prevent harm to the public. So it is with great honor, that I accept the position as President of the Missouri State Board of Nursing, to help carry out our mission.

I have served on the Board now for 4 years and have found it to be a very rewarding experience. Nursing regulation helps all nurses to be accountable and responsible for our scope of practice. Working on the discipline and practice committees has given me insight into the importance of nursing regulation and public protection.

During my 12 years as an RN, I have spent my career working in women's health either as a labor and delivery nurse or as a women's health nurse practitioner. As an APRN, I hope to offer my experience in advanced practice issues that may arise within the Board.

There have been many changes recently on the Board as new members have been appointed and with the change in presidency. We want to thank Dr. Teri Murray for her leadership as Board president over the last 3 years. Teri has served on the Board now for 7 years and provided the Board with her expertise in nursing education. Thank you, Teri, for your service and dedication as a Board member and president.

A special thank you also goes out to Kay Thurston, RN and Linda Conner, RN who have served as Board members for several years (7 and 5 respectively) and have completed their terms. The Board relies on all 9 members to come to the table with different areas of expertise and experience to promote the mission of the Board. These nurses have given their time and energy to serve the state of Missouri.

It is an exciting time to be working with the Board and the APRN task force to create new rules for the prescriptive authority bill that was recently signed by Governor Blunt. Although it is a lengthy process, it is important to ensure effective rules that will protect the public and enforce the new legislation. This is one of the many things that the Board will be working on over the next year.

I look forward to serving in this role and if you have suggestions or questions, please feel free to email me at nursing@pr.mo.gov. The Board strives to help nurses safely act in the numerous roles of the profession and if you have suggestion on how we might accomplish this goal more effectively, please let us know. We want to have open communication with nurses, hospitals, schools of nursing and other professions that are impacted by nursing.

GOVERNOR
The Honorable Matt Blunt

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Lori Scheidt, BS

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Executive Director Report

Authored by Lori Scheidt, Executive Director

Fiscal Year 2008 Statistics

The 2008 fiscal year for Missouri State government began July 1, 2007 and ended June 30, 2008.

The Board reviews all complaints that are filed against the license of a nurse. Following an investigation, the Board determines whether or not to pursue discipline. If the board decides that disciplinary action is appropriate, the Board may impose censure, probation, suspension, and/or revocation.

The Board of Nursing may take disciplinary action against a licensee for violation of the Nursing Practice Act (see 335.066, RSMo). The Board is authorized to impose any of the following disciplines singularly or in combination:

- Censure—least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.
- Probation—places terms and conditions on the licensee's license.
- Suspension—requires that the licensee cease



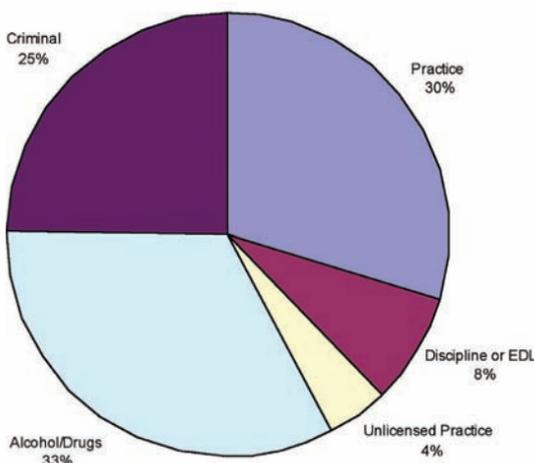
Scheidt

practicing nursing for a period not to exceed 3 years.

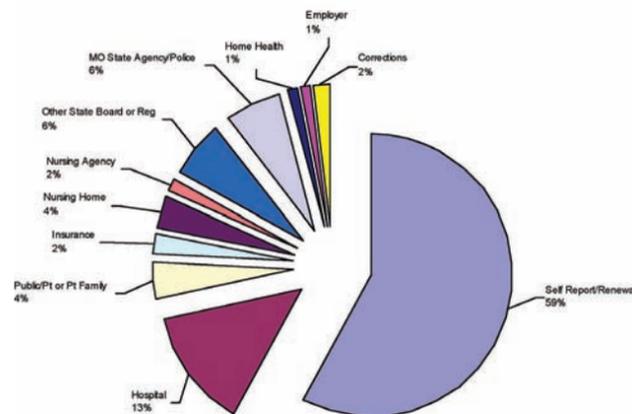
- Revocation—most restrictive discipline. The imposition mandates that the licensee immediately loses his/her license and may no longer practice nursing in Missouri.

The following chart shows the category of complaint and application reviews that were closed this past fiscal year. There were 2029 Board decisions made in fiscal year 2008.

FY 2008 Closed Categories of Complaints



FY 2008 Closed Complaints by Source



Executive Director Report continued on page 3

Presort Standard
US Postage
PAID
Permit #14
Princeton, MN
55371

current resident or

Licenses Issued in Fiscal Year 2008

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	Registered Nurse	Licensed Practical Nurse
Licensure by Examination (includes nurses not educated in Missouri)	3013	1321
Licensure by Endorsement	2141	321
Licensure by Renewal of a Lapsed or Inactive License	1421	411
Number of Nurses holding a current nursing license in Missouri as of 6/30/2008	87,798	24,646

Licensure Database Information

The average age of nurses continues to stay about the same. This is based on all nurses licensed in Missouri, regardless of where they reside.

Profession	FY2004	FY2005	FY2006	FY2007	FY2008
RN	45	46.12	46.28	46.35	46.62
LPN	44	45.13	45.36	45.00	45.32

The following two maps depict the average age by county and the count of the number of nurses in each county that had a current Missouri nursing license and Missouri address as of September 16, 2008.

Important Telephone Numbers

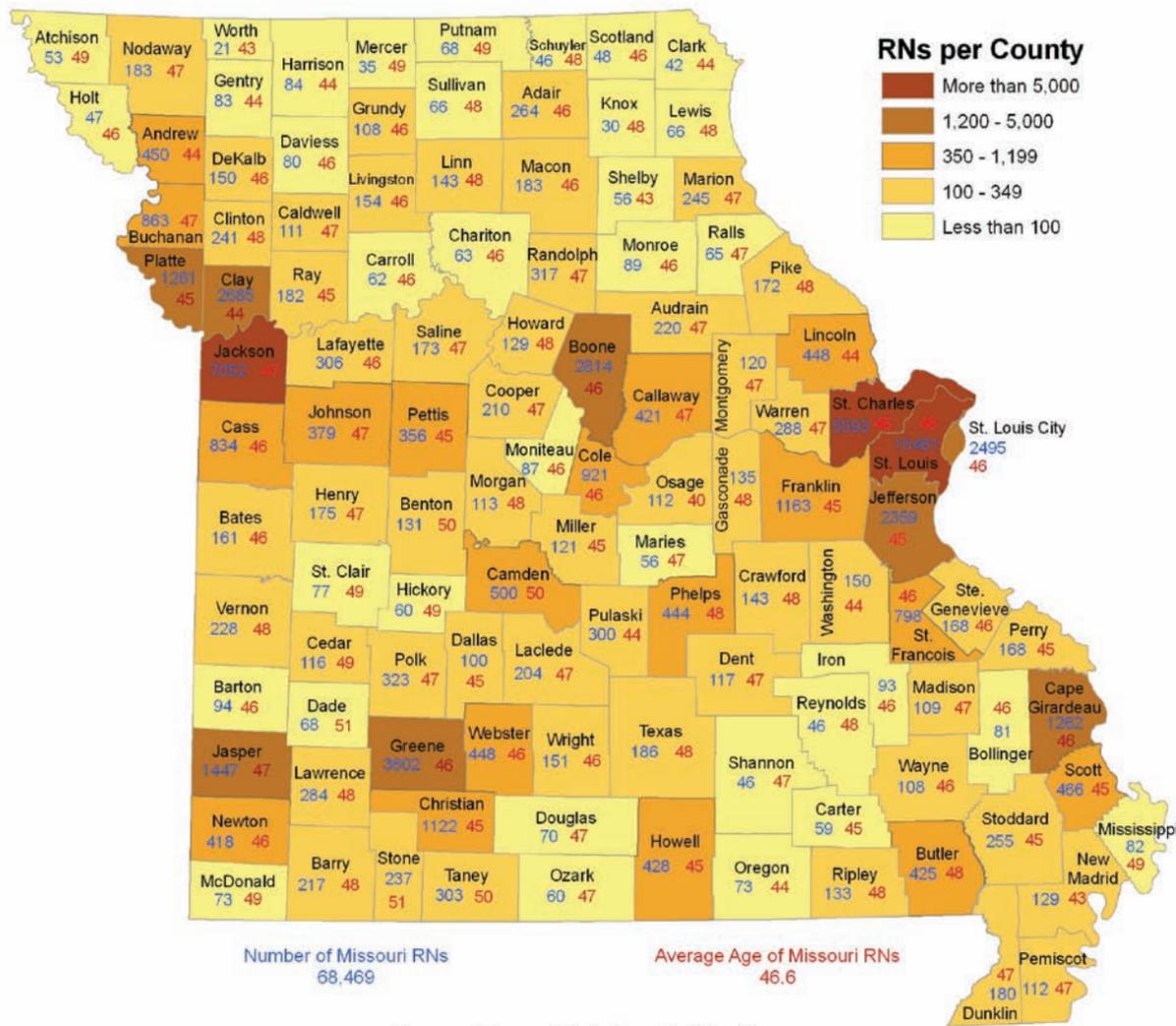
Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (MoSALPN)	573-636-5659
Missouri Nurses Association (MONA)	573-636-4623
Missouri League for Nursing (MLN)	573-635-5355
Missouri Hospital Association (MHA)	573-893-3700



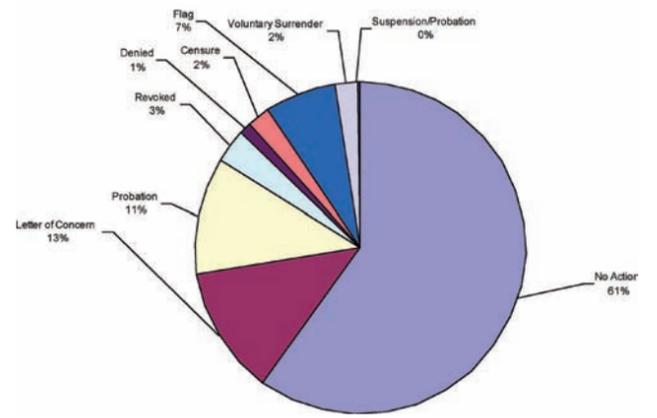
Executive Director Report continued from page 1

The next chart shows the actions taken by the Board for those complaints and application reviews.

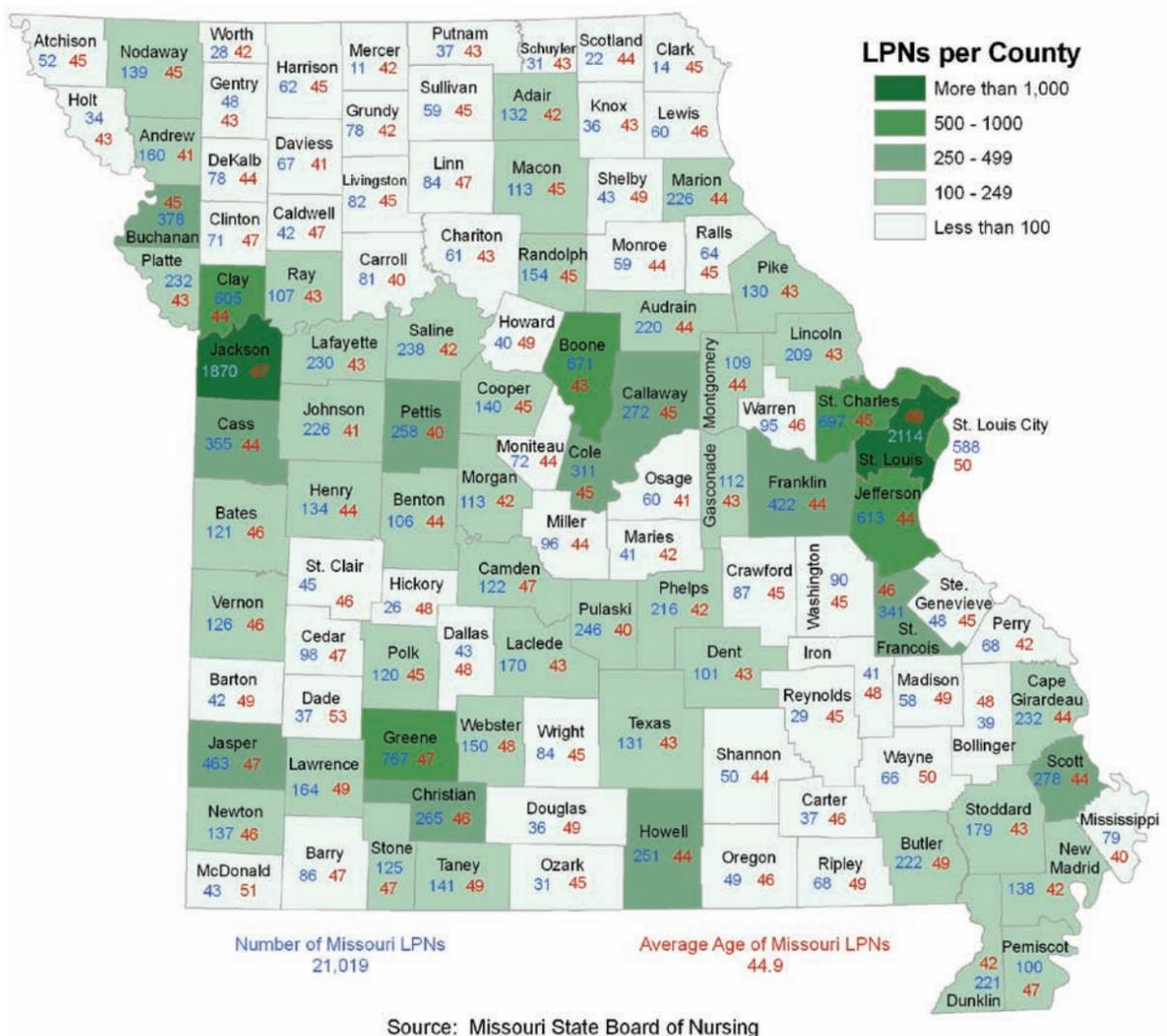
Registered Nurses in Missouri Number and Average Age by County, 2008



FY 2008 Complaints Final Actions



Licensed Practical Nurses in Missouri Number and Average Age by County, 2008





The Legal Perspective

Authored by **Mikeal R. Louraine, B.S., J.D.**
Legal Counsel

Board Meeting Questions and Issues

At the most recent full Board meeting, an issue arose that led to some questions and discussion. The issue arose when a licensee, in response to a question from the Board's attorney, stated that she wished to 'take the 5th'. Everyone understood that the licensee wished to invoke the protections of the 5th Amendment of the United States Constitution, which states, in part, "No person shall be ... compelled in any criminal case to be a witness against himself..." Acting as the hearing advisor for this case, I advised the licensee that she could not 'take the 5th' and should answer the question. I could tell by the confused look of several students that they did not understand why the licensee could not 'take the 5th' in that circumstance.

First, part of the answer is in the wording of the Amendment, it specifically states, "any criminal case." Cases heard before the State Board of Nursing are not



Louraine

criminal cases. They are administrative cases. They are handled in accordance with the Administrative Procedure Act found in Chapter 536 of the Revised Statutes of Missouri. The easiest way to tell the difference between a criminal and an administrative case is the remedy available to the finder of fact. If the case involves jail time and/or monetary fines, it's generally dealt with as a criminal case. If the remedy involves sanctions against a license, e.g. revocation, suspension or probation, it's generally an administrative case.

Second, the ability to 'take the 5th' can depend on the question. In the case before the Board, the question concerned the nursing employment of the licensee for the last five years. That question, honestly answered, is not going to incriminate a person. Therefore, the person cannot refuse to answer the question. However, if the question concerned potentially illegal activity, for example, "what did you do with the controlled substances that you failed to document?" the answer could incriminate the person. If the honest answer is that they consumed the narcotics, they could be incriminating themselves for illegally possessing a controlled substance. If the honest answer is that they sold the narcotics, they could be incriminating themselves for illegal sales of a controlled substance. If they don't answer honestly, they could be prosecuted for perjury. In that case, for that question, 'taking the 5th' would probably be the best course of action.

Other factors to consider are the statute of limitations and double jeopardy. In most, but not all, criminal cases, the statute of limitations, or the time within which criminal charges can be brought, is three years. In our example above, if the documentation errors were over three years old and the illegal possession or sale of the narcotics was over three years, the statute of limitations would have run out, no criminal charges would be possible and, therefore, the licensee would lose the ability to 'take the 5th'. Double jeopardy refers to the constitutional protection against being tried twice for the same crime. Specifically, "...nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb..." In our above example, if the license had been charged, tried and convicted, or acquitted, of illegal possession of a controlled substance,

she could not now attempt to invoke the protections of the 5th Amendment. Any answer she would give could not be used against her as she could not be tried for the same crimes again. Another example of this would be the OJ Simpson case. In the criminal trial, he chose not to testify and the State of California could not have forced him to give testimony against himself. However, in the subsequent civil trial, he was forced to testify. Because the criminal charges against him had been resolved, he could not refuse to answer questions based on the 5th Amendment. Without that protection, he was forced to testify.

Please keep in mind that these are very complex legal issues. This article should only be perceived as a brief glossing over of a very challenging subject matter.

A similar question concerns the right to counsel. This falls under the Sixth Amendment of the Constitution; "In all criminal prosecutions, the accused shall enjoy the right to... have the assistance of counsel for his defense." For most people, their familiarity with this constitutional protection comes from seeing the public defender represent people in criminal court. The court is required to inquire of the defendant whether or not they can afford the services of an attorney. If they cannot, the public defender is required to represent them. As with the Fifth Amendment, this protection is limited to criminal cases. As previously stated, cases that come before the Board of Nursing are administrative, not criminal. Does this mean that a licensee does not have the right to counsel? Absolutely not. A licensee always has the right to be represented, at any or all stages of a case, by an attorney. What it means is that, if you cannot afford the services of an attorney, the State of Missouri or the Board of Nursing will not provide one to you free of cost. I have discussed in previous articles the importance of being represented. I still maintain that when you are in an unfamiliar setting, like being investigated by the Board of Nursing, it is in your best interest to obtain legal counsel.

As always, thanks to the students who come to the hearings and pay enough attention to come up with good questions.



Discipline Corner

Authored by Janet Wolken, MBA, RN
Discipline Administrator

Missouri State
Board of Nursing
Discipline Committee
Members:

- Charlotte York, LPN, Chair
- K'Alie Breinig, RN, MN
- Autumn Hooper, RN
- Teresa McElyea, LPN
- Meg Shea, RN, PNP-BC
- Janet Vanderpool, RN, MSN



Wolken

On July 30, 2008 Mike

Boeger from the Bureau of Narcotics and Dangerous Drugs (BNDD) gave a presentation to Board of Nursing staff. The BNDD's authority is located under Chapter 195, RSMo and the Controlled Substances Act. The BNDD maintains a registry of individuals and firms who prescribe and dispense controlled substances.

I learned that the BNDD does not have any authority regarding clinical issues, has no powers of arrest, and are not able to impose monetary penalties.

The BNDD is concerned with where the controlled substance goes and they track it once it is in the hospital or office until it reaches the patient's hands. They do routine inspections and audit records to ensure that these firms and individuals are managing controlled substances properly. This routine inspection would include the records in the automated dispensing devices, withdrawal, wastage and the recorded administration in the medication administration records (MAR) at facilities.

Because the BNDD tracks the controlled substance from the hand of the practitioner to the patient's hands they would then be concerned with the diversion of drugs by nurses because the record keeping of those controlled substances has been altered. Nurses are human, they have high stress physical jobs and they have access to controlled substances every day in their work place. Because nurses administer controlled substances on a daily basis they feel more comfortable with medication when it comes to self administration. Due to these factors (and many more) nurses sometimes become addicted to drugs and divert them. As a fellow nurse you may want to be aware of how to recognize an impaired co-worker.

A pamphlet was distributed during the meeting entitled *Drug Addiction in Health Care Professionals*. The pamphlet is published by the DEA and has information that every nurse should be aware of. If you would like a copy of the pamphlet it may be found at http://www.dea diversion.usdoj.gov/pubs/brochures/drug_hc.htm. The information found in the pamphlet is copied below. I would like to

thank BNDD and the DEA for providing the information.

Drug Addiction in Health Care Professionals

The abuse of prescription drugs—especially controlled substances—is a serious social and health problem in the United States today. People addicted to prescription medication come from all walks of life. However, the last people we would suspect of drug addiction are health care professionals—those people trusted with our well-being. Yet health care workers are as likely as anyone else to abuse drugs.

Even though the vast majority of DEA registered practitioners comply with the controlled substances law and regulations in a responsible and law abiding manner, you should be cognizant of the fact that drug impaired health professionals are one source of controlled substances diversion. Many have easy access to controlled substance medications; and some will divert and abuse these drugs for reasons such as relief from stress, self-medication, or to improve work performance and alertness.

This guide will help you recognize the signs that may indicate that a colleague or co-worker is diverting controlled substances to support a substance abuse problem.

- What Are My Responsibilities?
- How Do I Recognize a Drug Impaired Co-Worker?
- Should I Become Involved?
- What If I Know That Drugs Are Being Sold or Stolen?
- What Can I Do to Help?

What are My Responsibilities?

You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

You have a professional responsibility to prescribe and dispense controlled substances appropriately, guarding against abuse while ensuring that patients have medication available when they need it.

You have a personal responsibility to protect your practice from becoming an easy target for drug diversion.

You must become aware of the potential situations where drug diversion can occur and safeguards that can be enacted to prevent this diversion.

How Do I Recognize a Drug Impaired Co-Worker?

- Drug abusers often exhibit similar aberrant behavior. Certain signs and symptoms may indicate a drug addiction problem in a health care professional. Have you observed some of the following signs?
- Work absenteeism—absences without notification and an excessive number of sick days used;
- Frequent disappearances from the work site, having long unexplained absences, making improbable excuses and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept;
- Excessive amounts of time spent near a drug supply. They volunteer for overtime and are at work when not scheduled to be there;
- Unreliability in keeping appointments and meeting deadlines;
- Work performance which alternates between periods of high and low productivity and may suffer from mistakes made due to inattention, poor judgment and bad decisions;
- Confusion, memory loss, and difficulty concentrating or recalling details and instructions. Ordinary tasks require greater effort and consume more time;
- Interpersonal relations with colleagues, staff and patients suffer. Rarely admits errors or accepts blame for errors or oversights;
- Heavy “wastage” of drugs;
- Sloppy recordkeeping, suspect ledger entries and drug shortages;
- Inappropriate prescriptions for large narcotic doses;
- Insistence on personal administration of injected narcotics to patients;

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Discipline Corner continued from page 5

- Progressive deterioration in personal appearance and hygiene;
- Uncharacteristic deterioration of handwriting and charting;
- Wearing long sleeves when inappropriate;
- Personality change—mood swings, anxiety, depression, lack of impulse control, suicidal thoughts or gestures;
- Patient and staff complaints about health care provider's changing attitude/behavior;
- Increasing personal and professional isolation.

Should I Become Involved?

Health care professionals often avoid dealing with drug impairment in their colleagues. There is a natural reluctance to approach a co-worker suspected of drug addiction. There is the fear that speaking out could anger the co-worker, resulting in retribution, or could result in a colleague's loss of professional practice.

Many employers or co-workers end up being "enablers" of health care practitioners whose professional competence has been impaired by drug abuse. Addicted colleagues are often given lighter work schedules, and excuses are made for their poor job performance. Excessive absences from the work site are often overlooked. Drug impaired co-workers are protected from the consequences of their behavior. This allows them to rationalize their addictive behavior or continue their denial that a problem even exists.

If you recognize the aforementioned signs or symptoms in a co-worker, it's time to demonstrate concern. You may jeopardize a person's future if you cover up or don't report your concerns. Many well-educated, highly trained, and experienced health care practitioners lose their families, careers, and futures to substance abuse. Tragically, some health care workers have even lost their lives to their drug addiction because the people who saw the signs and symptoms of their drug use refused to get involved.

By becoming involved, you can not only help someone who may be doing something illegal, but more importantly, your action could affect the safety and welfare of your addicted employee or coworker **AND** those patients or the public who may come in contact with him or her.

What If I Know That Drugs Are Being Sold or Stolen?

Drug abuse and drug dealing are serious problems that should be handled by qualified professionals. If you suspect that a drug deal is in progress, do not intervene on your own. Contact security or notify the police.

If you are a DEA registrant and become aware of a theft or significant loss involving controlled substances, you must immediately report the theft or loss to the nearest DEA office as well as your local police department.

What Can I Do to Help?

For some employees, the mere fact that their supervisor talks to them about their poor work performance is enough to help them change. For others, however, the problem may be more severe and require more drastic measures. The threat of losing a job may have more influence on a drug abuser than a spouse's threat to leave or a friend's decision to end a relationship. Many drug abusers will seek help for their problem if they believe their job is at stake, even though they have ignored such pleas from other people important in their life.

Drug addicts can recover, and effective help is available. Encourage your co-worker or employee to seek drug treatment assistance. Treatment programs range from self-help to formal recovery programs. A number of state licensing boards, employee assistance programs, state diversion programs and peer assistance organizations will refer individuals and their families to appropriate counseling and treatment services. These services will maintain the confidentiality of those seeking assistance to the greatest extent possible.

Department of Justice
Drug Enforcement Administration
Office of Diversion Control
Liaison and Policy Section
Washington, D.C. 20537

It is not the intent of this publication to reduce or deny the use of controlled substances where medically indicated. Nothing in this guide should be construed as authorizing or permitting any person to do any act that is not authorized or permitted under federal or state laws.

Additional information on DEA's Diversion Control Program is available at: www.deadiversion.usdoj.gov

Education Report



*Authored by Bibi Schultz, RN MSN,
Education Administrator*

**Missouri State Board of
Nursing Education Committee
Members:**

- K'Alice Breinig, RN MN
- Teri Murray, PhD, RN
- Janet Vanderpool, RN
- Charlotte York, LPN



Schultz

Adjunct Surveyor Response

I would like to take this opportunity to thank all of you who voiced interest and have applied to serve as adjunct surveyors for nursing program site visits. Your responses have been overwhelming. Nursing professionals from many areas of the state have contacted our office regarding this important process. Applications range from nursing professionals currently involved in nursing education to nurses actively caring for patients at the bedside.

In order to qualify applications for review, submission of the resume and one professional letter of recommendation is required. Many of you have completed this process and have been contacted to attend one of the adjunct surveyor orientation sessions.

On August 15th, 2008 we conducted the first adjunct surveyor orientation here at the MSBN board office in Jefferson City. As applications continue to arrive, review of documents is ongoing and many of you will be invited to attend a future session.

Currently all routine 2008 program survey site visits have been scheduled and adjunct surveyors have been selected. Later this fall scheduling for 2009 visits will begin. As you may know, the Education surveyor selection processes are carefully designed to efficiently match suitable adjunct surveyors with nursing programs. In order to avoid any conflict of interest, nursing programs are provided with the opportunity to agree to the services of selected adjunct surveyors. Should concerns arise, a different surveyor selection is made. It is our goal to provide regulatory data collection/evaluation services that are objective, reliable and efficient. I appreciate everyone's efforts to support this important process. Again, I would like to thank you for your great interest in this process.

Practice Corner

Authored by **Debra Funk, RN**
Practice Administrator

Missouri State Board of Nursing

Practice Committee Members:

- Amanda Skaggs, RNC, WHNP, Chair
- K'Alice Breinig, RN, MN
- Autumn Hooper, RN
- Teresa McElyea, LPN
- Teri Murray, PhD, RN
- Meg Shea, RN, PNP



Funk

Job Abandonment or Patient Abandonment?

We receive many calls and complaints related to abandonment issues. Sometimes it is difficult to determine the difference between job abandonment and patient abandonment. Abandonment can look different depending upon which side you stand on—the nurse or the employer. We have a Position Statement about Patient Abandonment on our website that I have included below.

MISSOURI STATE BOARD OF NURSING POSITION STATEMENT PATIENT ABANDONMENT

The Missouri State Board of Nursing believes that the provisions in Chapter 335 and its regulations reflect the State's public policy that its licensed nurses have a responsibility to faithfully serve the best interests of their patients.

In order to address the many calls received by the Board from licensed nurses seeking guidance on how to protect their individual licenses and also carry out their duty to protect their patients, the Board hereby seeks to clarify some of the parameters of patient abandonment with this position statement. This position statement, however, is meant to be only a general guideline as to what may constitute patient abandonment from the Board's perspective, since any and all complaints alleging patient abandonment are considered on a case-by-case basis by the Board.

Patient abandonment may include, but is not limited to, the following scenarios:

- Leaving the place or area of employment during an assigned patient care time period without reasonable notice to the appropriate supervisor, so that arrangements can be made for continuation of nursing care by qualified others.
- Leaving the workplace without adequately providing a patient status report to oncoming qualified personnel.
- Leaving an emergency patient care situation that would be considered overtly dangerous based on the standard of actions of a similarly qualified reasonable and prudent licensed nurse.

- Showing lack of competent attention to or leaving a patient in acute distress without proper notification of appropriate personnel and/or without making appropriate arrangements for continuation of nursing care.
- Making inadequate patient contacts, assessments, or interventions either directly or indirectly through improper supervision of other nursing care providers.
- Sleeping while on duty.

Provision of qualified, appropriate, and adequate numbers of personnel to care for patients are the responsibility of the employer. The Missouri State Board of Nursing has no jurisdiction over employment related matters.

The Missouri State Board of Nursing considers the following scenarios to be some examples of employer-employee issues, which, therefore, do not generally constitute instances of patient abandonment to the Board:

- Failure to work beyond previously agreed upon work time period¹.
- Refusal to work in an unfamiliar, specialized, or "high tech" patient care area when there has been no orientation, no educational preparation, or employment experience, without reasonable notice to the appropriate supervisor.
- Refusal to report to work.
- Failure to call employer or arrive for assigned work time period.
- Accumulation of "too many" days not worked.
- Failure to return to work from a scheduled leave of absence.
- Resignation from a position after completion of assigned patient care time period, such as an assigned shift, and not fulfilling the remaining posted work schedule.
- Termination of employer-employee relationship, after completion of an assigned patient care time period, by licensed nurse employee without providing employer with a period of time to obtain replacement for that specific position, such as resigning without notice.

Approved 12/4/2001

Revised 8/2007

An APRN Question: Do I need a Document of Recognition if I'm not in clinical practice?

The answer to this question is "Yes." If you represent yourself as an Advanced Practice Registered Nurse (APRN) you must be recognized by the Board. Some of the places where a nurse may represent themselves as an APRN include but are not limited to: a business card, resume or curriculum vitae, name badge, job description, job application, job interview, publication, or a presentation. The titles of Advanced Practice Registered Nurse (APRN), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Nurse Midwife or Certified Nurse Midwife (CNM) and Certified Registered Nurse

Anesthetist (CRNA) are protected titles in Missouri and may only be used by nurses recognized by the MSBN.

Update on SB724

The laws referring to the collaborative practice agreement (CPA) went into effect August 28, 2008. It is possible that further clarification of these laws may be accomplished through collaborative practice rule revision. This would be done by the Collaborative Practice Task Force which is made up of Board members from Healing Arts and the Board of Nursing. This group has not met as yet.

The laws describing controlled substance prescriptive authority by APRNs will go into effect once rules have been promulgated. A Task Force of APRNs met for the first time on September 25, 2008 to begin a phase of this process which involves the clarification of educational, preceptorial and practice requirements stated in the law.

We will keep you informed of our progress on the website, www.pr.mo.gov/nursing.asp, and in the newsletter.

¹ The Missouri State Board of Nursing has adopted the following resolution passed by the National Council of State Boards of Nursing, Inc. (NCSBN) at its August 2001 Delegate Assembly: NCSBN promotes safe and effective nursing practice in the interest of protecting public health and welfare. Therefore, National Council recognizes the professional responsibility of nurses to accept or decline overtime assignments based on their self-assessment of ability to provide safe care.



Licensure Corner

**Authored by Angie Morice
Licensing Administrator**

**Missouri State Board of
Nursing
Licensure Committee
Members:**

Charlotte York, LPN
Autumn Hooper, RN
Teresa McElyea, LPN
Meg Shea, RN, PNP



Morice

Graduate Nurse Status

Lately there seems to be some confusion regarding graduate nurse status and with graduate nurses working in Missouri who first become licensed in another state.

A graduate nurse of a nursing program may practice as a graduate nurse until he/she has received the results of the first licensure examination taken by the nurse or until ninety (90) days after graduation, whichever comes first.

There is a thirty (30) day grace period, for graduates who have successfully passed the first available licensing examination in another state following graduation, to obtain a temporary permit or license in Missouri after the graduate has received his/her results.

The nurse must stop practicing as a graduate nurse and be moved to a non-nursing position if:

- he/she fails the examination;
- their ninety (90) day graduate nurse status is expired; or
- after first passing the examination and becoming licensed in another state, their thirty (30) day grace period is expired.

Retired Nurse Status

A licensee wishing to place his/her license on retired status must submit the Retired Nurse Application and a

\$15.00 fee. The license must be current, unrestricted and undisciplined. To be retired from the profession means that the licensee does not intend to practice nursing for monetary compensation for at least two (2) years.

If you hold a retired nurse license, the licensee may use their nursing title and provide volunteer services as long as he/she does not receive monetary compensation for those services. The licensee will receive a license marked "Retired."

A renewal notice will be mailed to the retired nurse and the nurse will be required to complete the renewal form and return it with a biennial retired nurse renewal fee of \$15.00.

If the licensee wishes to reinstate his/her license back to active status, they must complete the form to renew an expired license found on the Board's website.

The Retired Nurse Application can be mailed to you by calling our office at 573-751-0681.

Name and address changes

Please notify our office of any name and/or address changes immediately in writing. The request must include your name, license number, your name and/or address change and your signature. Methods of submitting name and/or address changes are as follows:

- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, Missouri 65102.

Contacting the Board

In order to assist you with any questions and save both yourself and our office valuable time, please have the following information available when contacting the Board:

- License number
- Pen and paper



Investigations Corner

**Authored by Quinn Lewis
Investigations Administrator**

In previous newsletters the majority of articles posted in the Investigations Corner consisted of educating the public about the Board's investigations process. This quarter I decided to go in a different direction regarding my topic of discussion.

The Board's primary job is to protect the public. My philosophy is that protection begins with prevention. From an investigative standpoint there is a great opportunity to prevent some practice issues from occurring by giving the reader an opportunity to learn from the mistakes of others. Starting this quarter I will begin to present actual cases that the Board has reviewed and found the conduct to be in violation of the nurse practice act. Due to the wide range of complaints the Board receives, chances are there will be a case that will give a scenario that will prevent a future incident from occurring.

The names of all persons and locations have been changed to protect the identity of those involved.

This edition of Case of the Quarter was reported to the Board by the administrator of a long term care facility. The reporter stated that four nurses failed to follow doctor's orders and in the process committed a major medication error. It was reported that these four nurses, whom will be referred to as nurse A, B, C and D for the purpose of this report, committed a major medication error after a patient received several doses of a blood thinner without obtaining daily lab draws and confirming patient's INR per doctor's orders.

The following are facts discovered during the investigation:

Patient was admitted to the facility on a Saturday.



Lewis

According to records obtained during the investigation the patient received six doses of Lovenox along with his/her scheduled Coumadin between Saturday and Tuesday. The medication sheets indicate the patient had an order for Enoxaparin (Lovenox) 70mg subq BID, stop when INR>2.5 (0.7ml), with daily labs to be drawn. It was determined that Nurses A, B, C and D administered the Lovenox six times without confirming INR values for the patient. The four nurses also failed to contact the doctor to ask if the Lovenox or Coumadin should be held since there were no lab results to monitor the effects.

An exhibit of the investigative report shows a Physician Order Referral which states that a daily INR was ordered until further notice. The Order referral was started by Nurse A on Saturday. The lower portion of the order referral form was completed and indicates that phone calls were made to the lab but the lab never returned the calls. On Tuesday, contact was made with the lab and it was discovered that the lab thought that the daily draws were to begin on Tuesday. The lab then came to the facility on Tuesday for a blood draw. The results indicated a critical INR of 55.00. The patient was then rushed to the hospital.

Investigator interview with Nurse A:

Nurse A stated that when the patient was admitted to the facility on Saturday, the doctor was called and the orders were approved. Nurse A then called the Director of Nursing (DON) to ask how to set up a weekend lab. The DON didn't answer so she left a message. Nurse A told oncoming Nurse B that she was waiting on a call from the DON regarding the lab. Nurse A said that the DON called back after her shift was over, but Nurse B didn't know what the call was pertaining to, so the DON was never asked about obtaining a weekend lab.

Nurse A came in the next morning (Sunday) for her 7 AM shift and realized the lab had not been done. She called the lab and got the answering machine so she hung up. She did not know she was supposed to leave a message. She then called the on-call nurse and she didn't get an answer. Nurse A then went ahead and gave the Lovenox

injection again without a lab being drawn. Nurse A said that the information that a lab needed to be drawn was passed along again.

Nurse A returned to work on Tuesday, after being off on Monday and checked on the lab. The lab had been at the facility that morning to draw the patient's blood. Nurse A looked at the patient's medical records to see what everyone else was doing and since everyone had been giving the Lovenox injection Nurse A again gave the Lovenox to the patient that morning at 8 AM prior to receiving the lab results. Nurse A stated that later that morning the lab called with a critical INR level.

Nurse A was asked if a call was made to the DON on Saturday to inquire how to do a weekend lab. Nurse A stated, "Yes but the DON never called back during my shift. The DON called later but no one knew why I had made the call. "I told Nurse B that I had called the DON to ask about how to do a weekend lab."

Nurse A was asked if a note was left stating that a message had been left with the DON asking how to do a weekend lab. Nurse A stated that a note was not left, rather the oncoming shift was just told to ask the DON about it when the call was returned. Nurse A stated that she assumes that Nurse B forgot to ask about the lab and she never passed it on to the next shift.

Nurse A was asked if it ever occurred to her to contact the doctor about the labs not being drawn. Nurse A stated that the doctor brushed her off when she was confirming the orders on Saturday. Nurse A never thought to contact the DON on Sunday. Since no one reported that the DON called back on Saturday, she assumed that the DON was out of town.

Nurse A was asked if it was mentioned to the oncoming shift, during report on Sunday, that the lab needed to be drawn. Nurse A didn't remember if she said anything to the oncoming shift or not. Nurse A thought that it was reported because she was off Monday and she was worried about it.

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Nurse A was asked how many times she gave the Lovenox to the patient. She stated that the medication was given on "Sunday AM and Tuesday AM."

Nurse A was asked if the Lovenox injections were given knowing there were no lab results to determine if the patient had an INR > 2.5. Nurse A stated that no labs had been drawn and since everyone else continued to give the Lovenox, so did she.

Nurse A was asked what eventually happened to the patient. Nurse A stated that the patient was determined to have a critical INR after lab results were obtained. The patient was admitted to the hospital. The patient died a couple of days later, but it was determined that it was not the result of the medication error.

Nurse A was asked if she had ever worked weekends at the facility. Nurse A had worked weekends at the facility prior to this incident. She said she did not know nor did anyone else know how to do weekend lab requests.

Nurse A was asked if there was anything she would have done differently. Nurse A would have continued to call the DON, the on call nurse, the Doctor and the Administrator until someone was reached that knew what to do in this situation.

Nurse A concluded by stating that she has attended numerous in service trainings regarding how to do weekend labs. Nurse A also added that she was a new graduate nurse at the time.

Investigator interview with Nurse B:

Nurse B worked the evening shift on Saturday and the patient was already there when Nurse B came to work. Nurse B stated that Nurse A told her during report about the new patient. Nurse B said that she knew that Nurse A had called the DON, but didn't know why. Nurse B stated that the DON called back after Nurse A had left for the evening.

Nurse B was asked what Nurse A told her during report, Nurse B said that she did not remember Nurse A telling her about lab work for the patient. Nurse B stated that she did remember Nurse A stating that she needed a lab over the weekend, but she didn't know how to get a lab done without getting a stat order. Nurse B said that Nurse A stated that she would handle it and never mentioned that Nurse B needed to do anything about the lab. Nurse B stated that Nurse A left instructions to give the patient his/her evening dose of Lovenox, and Nurse B stated, "And I did."

Nurse B was asked if the Lovenox med card had any instructions on it. Nurse B stated, "On the Lovenox card it was written to give Lovenox BID until INR was greater than 2.5. I looked through the paperwork for INR results and I didn't find one. So I went ahead and gave the Lovenox."

Nurse B was asked what she told the oncoming shift about the patient. Nurse B said that she mentioned that the patient was on Lovenox.

Nurse B was asked if anyone was told about the labs. Nurse B didn't remember and that she just assumed that Nurse A took care of it.

Nurse B was asked if she gave a dose of Lovenox on the Sunday evening shift. Nurse B stated "Yes I did give another dose of Lovenox on Sunday evening."

Nurse B was asked if she looked for lab results before giving the Sunday evening dose of Lovenox. Nurse B stated, "Yes and there still wasn't anything. At this time I was hoping the results were on the way." Nurse B was asked if she ever called anyone about the labs before giving the Lovenox. Nurse B stated, "No I did not."

Nurse B was asked if it ever occurred to her to call someone about the labs and the Lovenox. Nurse B stated, "No, because I thought it had been taken care of. Nurse A never told me specifically to get a lab done on the weekend. I assumed that Nurse A had taken care of it, because she never mentioned it again and she never left a note on the clipboard. The only note I got from her was to give Lovenox."

Nurse B was asked what happened to the patient. Nurse B stated that the patient had a critical INR level, was sent to the ER, and later died. Nurse B said that the doctor advised that the patient's INR levels were stabilized within one hour due to a vitamin K shot that was given at the facility. Nurse B stated that the doctor opined that the patient passed away from an illness that had nothing to do with the Lovenox injections.

Nurse B was asked if she would have done anything differently. Nurse B stated, "Yeah, I would double check on all of that. I would not stop until I had answers about the labs. And I also would make sure what drugs the patients are on. There are so many generic brands. Now if I don't know what it is I look it up."

Investigator interview with Nurse C:

Nurse C stated she worked the 7 AM-3 PM on Monday. The night nurse reported the patient had been admitted on Saturday. Nurse C said there was a dressing change during the night and a pain medication had been given. Nurse C stated that the PT/INR, Coumadin, and Lovenox were mentioned, but she didn't remember who gave report.

Nurse C stated that the medication cards were on the counter in the med room and she saw the Lovenox with the patient's med card on it. Nurse C said that she had not had a chance to look at the patient's chart or meds. Nurse C stated that she took the card and saw that it said to stop Lovenox when INR was greater than 2.5. Nurse C stated that she went ahead and gave the patient an injection of Lovenox. The syringe is pre-filled from the pharmacy and the one she gave had 100mg. Nurse C stated that she should have wasted 30mg. The med card said 70mg of Lovenox, and the MAR was correct.

Nurse C was asked if she ever looked for any lab results prior to giving the Lovenox injection. Nurse C stated that she never looked for any labs.

Nurse C was asked if she was busy during her shift.

Nurse stated, "Always in the morning. You just hit the floor running."

Nurse C was asked how many doses of Lovenox she gave. Nurse C stated that she only gave one dose.

Nurse C was asked what she told the oncoming shift about the patient. Nurse C stated that she told the oncoming nurse that the patient had a 6 PM Lovenox to give.

Nurse C was asked if there was anything she would have done differently. Nurse C stated, "I would have read that med card and gone to the chart and looked for lab work. And not finding any lab work, I would have called the doctor and said I have no lab work what do you want me to do? Then if he would have made a stat order, I would have had it drawn."

Investigator interview with Nurse D:

Nurse D stated that she worked the 3 PM-11 PM shift on Monday. Nurse D said that she received report from Nurse C. Nurse D stated that Nurse C told her that the patient had been brought in from the hospital and he/she was not eating well and to keep doing vitals, turning and intake. Nurse D stated that she and Nurse C finished counting narcotics and she asked Nurse C about the Lovenox and Nurse C instructed her to give the Lovenox at 8 PM. Nurse D said that she gave the patient his/her 8 PM dose of Lovenox.

Nurse D was asked, what did the Lovenox med card say? Nurse D stated that the Lovenox med card said to give the Lovenox until INR is greater than 2.5, but she didn't remember seeing that at the time.

Nurse D was asked if she looked for labs prior to giving the Lovenox injections. Nurse D stated, "No I did not. In hindsight, I was thinking that the labs are usually drawn early in the morning, so I just thought that since the Lovenox had been given in the morning then it was ok to give it in the evening because only one lab was drawn daily. The lab comes in to draw between 5:30 AM and 6 AM. This is for normal labs. If lab results are needed earlier than this it would have to be a stat order."

Nurse D was asked how many Lovenox injections she gave. Nurse D said that she gave only one injection of Lovenox at 8 PM.

Nurse D was asked if she mentioned Lovenox to the other shift. Nurse D stated, "I'm sure I did, it's BID, 8 and 8."

Nurse D asked if there was anything she would do differently. Nurse D stated, "Now, anytime we have someone on Lovenox, I will review all of the orders. I read new admissions and I check Coumadin orders. We had a lot of in-services as a result of this. We were in-serviced regarding labs and how to get results, new admits, and Coumadin and Lovenox. I know this was not intentional."

As you can see by reading this case there were numerous break downs in the system. Lack of communication among the individuals involved and disregard for written orders led to a major medication error and put the patient at risk. I hope this case will serve as educational resource to prevent a similar situation from occurring in practice.

Summary of Actions September 2008 Board Meeting

Education Matters

Full Approval

- Full approval was granted for Missouri Southern State University, Baccalaureate Degree Program #17-510.

Curriculum Changes

- Request for curriculum revisions was approved for Goldfarb School of Nursing at Barnes-Jewish College, Baccalaureate Degree Program #17-521
- Request for curriculum revisions was approved for Franklin Technology Center, Practical Nursing Program #17-195.
- Request for curriculum revisions was approved for Pemiscot County School of Practical Nursing Program #17-143.
- Request for curriculum revisions was approved for Rolla Technical Center, Practical Nursing Program #17-184.

Relocation Requests

- Request for relocation was approved for University of Central Missouri, Baccalaureate Degree Nursing Program #17-573 contingent upon relocation site survey.

Enrollment Changes

- Request to increase enrollment from 300 to 350 students was approved for Goldfarb School of Nursing at Barnes-Jewish College, Baccalaureate Degree Nursing Program #17-521.
- Request to increase enrollment from 24 to 36 students was approved for State Fair Community College, Associate Degree Program #17-408.
- Request to increase enrollment from 35 students per class to 45 students per class was approved for Colorado Technical University, Practical Nursing Program #17-152.
- Request to increase enrollment from 30 to 35 students was approved for one year only for Texas County Technical Institute, #17-135.

Letters of Intent to begin programs

- A Letter of Intent from Sanford Brown, ADN Program #17-421 to begin a pilot program for Allied Health Graduates was acknowledged.
- A Letter of Intent from Crowder College to establish a new ADN campus in Cassville was acknowledged.
- A Letter of Intent for ITT Technical Institute, Inc. to establish a new Associate of Science in Nursing Program in the St. Louis area was acknowledged.

Surveys

- Numerous survey reports were reviewed and accepted.

Discipline Matters

The Board held 10 disciplinary hearings and 22 violation hearings.

Licensure Matters

The Licensure Committee reviewed 30 cases. Results of reviews as follows:

- Applications Approved—4
- Applications Approved with letters of concern—7
- Applications Approved with probated licenses—4
- Applications tabled for additional information—2
- Applications Denied—12
- Revocation—1

Pain and Symptom Management

*Authored by Tricia Schlechte, MPH, BSN
Policy and Intervention Analyst
Missouri Department of Health
and Senior Services*

Pain is the most common reason Americans seek medical attention. In 2005, three of every ten Missourians reported that pain made it hard to do self-care, work or recreation during the preceding month.

In 2003, the state legislature established the Missouri Advisory Council on Pain and Symptom Management within the Department of Health and Senior Services. The 19 member Council which includes two nurses appointed by the Board of Nursing, reviews guidelines; makes recommendations on acute and chronic pain treatment that can be integrated into the customary practice of health care professionals; analyzes statutes, rules and regulations; and examines the needs of targeted populations.

In 2004, a series of town hall meetings were held throughout the state to obtain input from persons experiencing severe or chronic pain and the health care providers who care for them. The majority of individuals identified the lack of healthcare provider knowledge regarding pain assessment as a primary barrier to proper pain care. Pain is one of the most universally experienced phenomenon and yet healthcare providers practice with many misconceptions about pain. These include a lack of understanding that uncontrolled acute pain increases the risk for developing persistent debilitating pain, a fear of prescribing opioid pain medications despite available guidelines and policies, and a lack of appreciation of the need for interdisciplinary approaches to care.

Many of the individuals provided testimony at the town hall meetings that consumers also lack knowledge regarding optimal pain therapy, as well as a failure to understand the consequences of untreated pain. Patients and families need to be educated and empowered to take a more active role in their care.

The Council sponsors speakers for conferences of health professionals and provides links to continuing education opportunities at the following web site <http://www.dhss.mo.gov/PainManagement/CEU.html>. It has also developed a consumer brochure "Managing Pain Begins With You" that is available at no charge. The brochure may be downloaded or ordering instructions obtained from <http://www.dhss.mo.gov/PainManagement/EducationalResources.html>.

For additional information about pain and symptom management, the Council, or to view guidelines, related links or the complete town hall report, visit <http://www.dhss.mo.gov/PainManagement/> or contact Tricia Schlechte, Chair of the Council at 573-751-0950.

Schedule of Board Meeting Dates Through 2009

December 3-5, 2008
March 11-13, 2009
June 3-5, 2009
September 9-11, 2009
December 2-4, 2009

Meeting locations may vary. For current information please view notices on our website at <http://pr.mo.gov> or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at <http://pr.mo.gov>

NCSBN Partners with Group to Help Prevent Unethical Recruitment of Foreign-Educated Nurses

Contact: Dawn M. Kappel
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Chicago—The NCSBN Board of Directors approved the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses at their July 2008 meeting.

This consensus effort was led by AcademyHealth, a non-partisan, scholarly society for health services researchers, policy analysts and practitioners. A Task Force composed of representatives of unions, health care organizations, educational and licensure bodies, and recruiters joined forces to provide voluntary guidelines that aim to ensure the growing practice of recruiting foreign-educated nurses (FENs) to the U.S. is done in a responsible and transparent manner.

The Code of Conduct provides voluntary guidelines that aim to ensure that the growing practice of recruiting foreign-educated nurses is done in a responsible and ethical manner. It is designed to increase transparency and accountability throughout the process of international recruitment and ensure adequate orientation for FENs. It also provides guidance on ways to ensure recruitment is not harmful to source countries.

NCSBN issued its own position statement on this subject in 2006. The Ethical Recruitment of Nurses for Licensure states that:

NCSBN respects the right of nurses to determine the country in which they choose to work. A thorough decision making process by the nurse can only be made with complete information concerning the implications of relocation. Any recruitment of nurses for the U.S. workforce must be ethical. High ethical standards in recruitment are supported by NCSBN. Recruitment must not mislead, intimidate or exploit. The complete document can be found at <https://www.ncsbn.org/ethicalrecruitment.pdf>

Laura Rhodes, NCSBN President, remarks, "NCSBN believes all nurses have a right to work where they choose and are qualified to do so, regardless of their country of origin. We believe this code will assist nurses in making good decisions about when and where to work."

The Code of Conduct has been endorsed by numerous groups in addition to NCSBN, including the American Nurses Association, the American Association of International Healthcare Recruitment, the National Association for Home Care and Hospice, several large recruiters and multiple associations of internationally educated nurses.

A copy of the Code of Conduct and background study are available at <http://www.fairinternationalrecruitment.org/> or <http://academyhealth.org/international/nurses2006.htm>.

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit organization whose membership comprises the boards of nursing in the 50 states, the District of Columbia and four U.S. territories.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number.

PROBATIONARY LICENSE

Listed below are individuals who were issued an initial probationary license or had their expired or inactive licenses renewed on a probationary status by the Board during the previous quarter with a brief description of their conduct.

Name	License Number	Violation	Effective Dates of Restricted License
Keri Lyn Jones Dixon MO	RN2008019518	On December 12, 2001, Licensee pled guilty to the Class B Felony of Dealing in a Schedule II Controlled Substance in the Superior Court of Marshall County, Indiana.	7/2/2008 to 7/2/2010
Demetria Toyce Lewis Kansas City MO	PN2008020435	On January 29, 2007 Licensee had a drug screen that was positive for cocaine and methadone. Licensee had a valid prescription for methadone. Licensee admitted to the Board's investigator that she knowingly used cocaine in a sexual situation with her husband. Licensee denies being addicted to, or habitually using, cocaine.	7/10/2008 to 7/10/2013
Sarah Louise Ode Saint Louis MO	RN2008019519	On November 13, 2000, Licensee pled guilty to the offense of Unlawful Consumption of an Alcoholic Liquor in the Circuit Court of Saline County, Illinois. On December 3, 2001, Licensee pled guilty to the misdemeanor of possession of under thirty-five grams of marijuana in the Associate Circuit Court of Camden County, Missouri. While enrolled in St. Louis Community College's Nursing program, Licensee submitted to a drug screen which was positive for marijuana.	7/2/2008 to 7/2/2009
Shannon E Stigall Kansas City MO	RN2008026549	On June 27, 2007, Licensee pled guilty to the misdemeanors of DWI and possession of less than 35 grams of marijuana in the Associate Circuit Court of Clay County, Missouri.	8/25/2008 to 8/25/2010

CENSURE

Listed below are the individuals who were given the discipline of censure. This is the least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.

Name	License Number	Violation
Sheila Blair High Ridge MO	PN049269	Licensee practice nursing while her license was lapsed.
Kathleen J Chirco Saint Louis MO	RN151985	Licensee practiced nursing while her license was lapsed.
Stacy L Davidson Grain Valley MO	RN146677	On September 4, 2007, Licensee inappropriately touched a fellow employee.
Tina Marie Feenstra O Fallon MO	PN2001012870	On August 12, 2007, Licensee was working with a patient that needed to have an antibiotic administered via IV. Licensee was not IV certified. After several requests for assistance were unsuccessful, licensee flushed the IV line and administered the IV antibiotic herself.
Sherry L Feltrop Jamestown MO	RN093729	On May 4, 2004, Licensee entered a guilty plea to Possession of Marijuana and Possession of Drug Paraphernalia in the Associate Circuit Court of Moniteau County, Missouri.
Christia L Goolsby Kansas City MO	PN043183	Licensee falsified her time sheet while working for a home health agency.
Connie J Hudson Mc Fall MO	PN048414	Licensee practiced nursing while her license was lapsed.
Catherine G Jaegers Hiram MO	RN091141	On April 18, 2004, Licensee made various charting errors and was observed altering a medication record after her shift had ended. Licensee admitted that she was suffering from an addiction to prescribed medications. Licensee was allowed to return to work after undergoing inpatient and outpatient treatment and signing a "Conditions of Employment Agreement."
Karla A Noe Walker MO	RN111856	On August 11, 2007, an individual, (Patient 1) appeared in the emergency department after being struck in the head by a bottle. Licensee made contact with Patient 1, applied Matisol wound adhesive preparation and a Steri-Strip bandage and discharged Patient 1. The emergency department physician reported that he was not made aware of Patient 1 and did not evaluate the patient. No triage evaluation was documented. On January 20, 2007, a child (Patient 2) was brought to the facility for treatment of a facial laceration and dental injury. After contact with Licensee, the parent of Patient 2 chose to leave the department to seek care elsewhere. Licensee failed to complete documentation on this patient and failed to complete a triage report. There is no documentation of the patient/parent refusal of care. The family of Patient 2 called the Emergency Department Director and informed the Director that no physician assessment occurred. On January 30, 2007, a child (Patient 3) appeared in the emergency department for treatment. After a conversation with Licensee and physician in triage, the parent/patient left the department. There was no record that Patient 3 ever appeared in the emergency department on January 30, 2007.
Bruce L Spear Sedalia MO	PN046640	Licensee was terminated for performing duties outside of the scope of practice for a LPN by administering an IV Push to a resident.

PROBATION

Name	License Number	Violation	Effective Dates of Probation
Jennifer Crockarell West Plain, MO	RN2000163404	<p>On July 23, 2007, Respondent’s supervisor received an anonymous telephone call stating that Respondent had used Methamphetamines the prior week end. Respondent denied taking methamphetamine and volunteered to submit to a drug screen. The results were positive for amphetamines.</p> <p>This licensee’s information was listed in last quarter’s newsletter. However, the entry incorrectly stated that the licensee tested positive for methamphetamine. The Board apologizes for the misprint in our newsletter. We do employ strict quality assurance guidelines which includes that the cause for discipline comes directly from the legal agreement. Unfortunately, the name of the drug for which the licensee tested positive was overlooked by both the licensee and board staff prior to execution of the agreement with the licensee.</p>	4/26/08 to 4/26/12
Bernice C Bendure Browning MO	PN052371	<p>On August 14, 2007, Licensee was placed on the Missouri Department of Health and Senior Services Employee Disqualification List for a period of four years for patient abuse.</p>	6/4/2008 to 6/4/2011
Angela M Boulton Saint Louis MO	RN151969	<p>Licensee removed Demerol 50mg and Morphine 10mg out of the pyxis for patient C.C. Licensee failed to document the administration and/or wastage of any of the medication withdrawn for patient C.C. Licensee failed to document the administration and/or wastage of the medication withdrawn for her patient. In addition, Licensee failed to follow physician orders when she withdrew more than double the amount the physician’s order called for.</p> <p>Licensee removed Morphine 10mg twice from the pyxis for patient C.C. Licensee failed to document the administration and/or wastage of the medication withdrawn for her patient.</p> <p>Licensee removed Morphine 10mg on patient K.K. Licensee was not assigned to patient K.K. on the evening she withdrew the Morphine. The nurse assigned to patient K.K. removed 2mg of Morphine (4 minutes after Licensee removed the 10mg). The 2mg is documented by the nurse caring for the patient. Licensee failed to document the administration and/or wastage of the medication withdrawn for her patient.</p> <p>On or about July 26, 2006, Licensee removed Morphine 10mg Morphine 2mg for patient J.D. A total of 6mg in 2mg increments were documented. Licensee failed to document the administration and/or wastage of all medication withdrawn for her patient.</p> <p>On or about May 30, 2006, Licensee was observed in a restroom near the operating room leaving blood and a syringe on the floor. Licensee was requested by staff to submit to a drug test. On or about May 30, 2006, Licensee submitted to a drug screen which was positive for Antihistamines, Benzodiazepines, Cocaine and Marijuana.</p> <p>Licensee did not possess a valid prescription for Cocaine or marijuana.</p>	6/28/2008 to 6/28/2013

The Board of Nursing is Requesting Contact from the Following Individuals:

Michelle Burch—RN 200162362
Gladys Warrior—PN 055206
Elizabeth Mott—RN148141
Kathy Skeels-Stewart—RN144477
Adrianna Wolverton—RN129667
Careissa Comley—PN2001019701
Diana McFatrach—RN145424
Tina Campbell—RN110664
Charlene Franken—RN2000163726

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

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Name	License Number	Violation	Effective Dates of Probation
Michael A Bowman Hartford IL	RN074514	On September 8, 2004, in response to a violent physical outburst of a patient, Licensee grabbed the patient by the neck and throat to restrain him. This resulted in the patient receiving a chipped tooth and mouth injury. Licensee told patient, "You will go back down to the ground and you will not like what happens." In response to a violent outburst, Licensee fell on top of patient to restrain him. When asked to get off of patient by his parents, Licensee responded, "I am in charge here and I make the decisions." Licensee failed to adequately document the treatment and care, especially the therapeutic holds and resulting injuries sustained from that treatment. Licensee failed to adequately document that patient was combative during the times he applied restraints. Licensee failed to professionally communicate with patient in response to the violent physical outburst by patient. Licensee failed to administer appropriate therapeutic holds as prescribed by the Crisis Prevention Institute and was in violation of the hospital policy and procedure.	7/4/2008 to 7/4/2009
Tereasa L Brand Eldridge MO	RN153562	Licensee was required to contract with NCPS, Inc. to schedule random witnessed screening for alcohol and other drugs of abuse. Licensee needed to be contracted with NCPS by January 25, 2008. Licensee did not activate her contract with NCPS, Inc. until June 3, 2008. Licensee was required to undergo a thorough evaluation for chemical dependency performed by a licensed chemical dependency professional within (6) weeks from the effective date of the Settlement Agreement. The Board has never received a thorough chemical dependency evaluation submitted on Licensee's behalf.	6/16/2008 to 6/16/2011
Mary J Brooks Springfield MO	RN078611	On May 13, 2004, Licensee and the Colorado State Board of Nursing entered into a Stipulation and Final Agency Order. Pursuant to the terms in the Colorado Order, Licensee permanently relinquished her Colorado nursing license and the right to practice as a professional nurse in Colorado.	7/23/2008 to 7/23/2010
Janet S Clark Saint Joseph MO	PN028311	On August 15, 2007, Licensee pled guilty to the charge of Stealing. On May 4, 2007, Licensee tested positive for amphetamines. Licensee does not have a valid prescription for amphetamines.	8/5/2008 to 8/5/2011
Patricia Gail Cooksey Savannah MO	RN2004007049	Licensee violated the terms of the disciplinary agreement by failing to call NCPS.	7/2/2008 to 4/26/2011
Sheila M Davis Fulton MO	PN2001024696	Pursuant to an Order of the Administrative Hearing Commission, the Board has jurisdiction to discipline Respondent's license under §§ 335.066.2(1) and (14) RSMo.	6/16/2008 to 6/16/2013

Probation continued on page 16

New Board Members Appointed

The Board is pleased to announce that three new board members have been appointed in the last 3 months. Please join us in welcoming Meg Shea, MS, RN, PNP-BC, Janet Vanderpool, MSN, RN, and Teresa McElyea, LPN to the Board.

Margaret (Meg) Shea, MS, RN, PNP-BC was appointed to the Board of Nursing in July 2008. Ms. Shea received her bachelor's degree in nursing from the University of Tulsa in 1976. She holds a masters degree in nursing from the University of Oklahoma in 1983, specializing in the nursing care of children. She received her post master pediatric nurse practitioner certificate from the University of Missouri, St. Louis in 1996.



Shea

Ms. Shea is currently a pediatric nurse practitioner in the renal division of the Department of Pediatrics, Washington University School of Medicine at St. Louis Children's Hospital. She works in an advanced practice role caring for children on dialysis and with various acute and chronic kidney diseases. She has been a Certified Nephrology Nurse (CNN) since 2003. Previously she worked as an advanced practice nurse in diabetes care at St. Louis Children's Hospital. Prior to returning to St. Louis in 1992 she worked in various nursing positions at Denver Children's Hospital and at St. John Medical Center in Tulsa Oklahoma.

Ms. Shea is active in a number of professional organizations within the pediatric and renal community. She was member of a volunteer team that traveled twice to Eritrea, Africa to provide diabetes education to nurses throughout the country.

Meg is married and she and her husband have five adult children. Her hobbies include golf, cooking and needlepoint.

Janet Vanderpool, MSN, RN was appointed to the Board of Nursing August 20, 2008. Janet earned an Associate of Applied Science Degree in Nursing from Trenton Junior College, a Bachelor of Science Degree in Nursing from Northwest Missouri State University, and a Master of Science Degree in Nursing from the University of Phoenix.



Vanderpool

Janet has worked as a Registered Professional nurse in rural North Central Missouri in various roles for the past 28 years. For 8 years Janet worked in the acute care setting. For the last 20 years nursing education has been her area of emphasis; 14 years as a classroom and clinical instructor, 5 years as Associate Dean of Allied Health Sciences and 1 year as Dean of Allied Health Sciences at North Central Missouri College in Trenton Missouri.

Janet lives in Princeton, MO with her husband Gary. She has one child, Clint and a granddaughter Kohner. Janet plays the piano, enjoys reading, and loves working in the garden.

Teresa McElyea, LPN was appointed to the Board of Nursing in August 2008. She attended the South Central Area Vocational Technical School of Practical Nursing in West Plains, Missouri graduating in 1986 and is currently a certified CPR instructor with the American Red Cross. For the past 22 years she has worked in several areas of nursing including hospital, long-term care, private duty, school and clinics. Teresa has spent the last 18 years in the clinic setting with 8 of those years also serving as a school nurse. She currently works for the Cabool Medical Clinic as well as working prn for Cox Health Systems.



McElyea

In addition to serving on the Board of Nursing she is also a member of the Willow Springs Park Board, volunteer for the local YMCA and served on the Willow Springs School Health Advisory Committee. She is a past member of the Missouri Association of Licensed Practical Nurses.

Teresa is married and has 2 daughters who are currently attending college in Springfield and Branson. She is a member of the Pomona Christian Church and has served in various capacities.

Probation continued from page 15

Name	License Number	Violation	Effective Dates of Probation
Marietta Lea Evans Saint Louis MO	PN2007005125	Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Licensee has failed to call in to NCPS, Inc. on fourteen (14) days. On May 3, 2007 and October 9, 2007, Licensee was advised that she had been selected to provide a urine sample for screening. Licensee failed to report to a laboratory to provide the requested sample. On January 23, 2008, the Discipline Administrator advised Licensee of a positive drug test result and requested that she have her prescribing physician fill out a Prescription Identification Form. The Board did not receive the Prescription Identification Form from Licensee's prescribing physician.	6/16/2008 to 2/14/2010
Tina Bee Fields Pleasant Hill MO	RN2002014647	In January 2003, Licensee began diverting Darvocet for personal consumption. In October 2004, Licensee began diverting Vicodin and Percocet for personal consumption. In January 2005, Licensee began diverting syringes of Morphine and Demerol for personal consumption. On March 15, 2005, Licensee was confronted by her supervisor regarding discrepancies with medications. Licensee admitted to the diversion of medications for personal consumption. On April 11, 2005, Licensee completed outpatient therapy.	8/26/2008 to 8/26/2010
Melissa A Gilmore Bernie MO	RN131588	On October 31, 2006, Licensee purposely drove her truck into the entrance of a Church. Licensee vandalized the entire church and parsonage. Licensee damaged the pastor's car and threatened the pastor's wife with a pipe. Licensee pled guilty to Property Damage.	6/28/2008 to 6/28/2011
Cynthia L Higgins Jefferson City MO	PN046551	Licensee was asked to submit to a drug screen due to a discrepancy regarding a controlled substance. Licensee submitted to the drug test which was positive for Oxazepam. Licensee stated that she did not have a prescription for Oxazepam and further stated that she had taken valium that a friend had given her.	7/30/2008 to 7/30/2010
Stephanie Kay Johnson Smithville MO	PN2005039297	A resident had a prior history of stroke and her physician had recently taken her off Coumadin. On June 16, 2006, the family reported to nursing staff, including Licensee, that the resident had exhibited several minutes of difficulty feeding, dropped utensils, had difficulty speaking, and that the resident had complained of the right hand and arm "going to sleep." Licensee conducted a brief assessment of the resident, but did not document her findings in the resident's medical chart. Sometime just before 5 p.m., Licensee faxed the resident's change in condition information to the physician. Licensee did not attempt to call or page the physician. The physician was out of the office from Friday, June 16 through Sunday, June 18, 2006. On Monday morning, June 19, 2006, the resident was found unresponsive by an aide at 0705. The resident suffered a stroke and was transferred to a hospital and died on June 23, 2006.	7/31/2008 to 7/31/2010
Doris D Tatum-Judon Kansas City MO	PN026034	The central supply manager stated that at approximately 2:00 p.m. on May 31, 2007 the pulse oximeter was broken therefore she discarded the machine and ordered a new machine. The new pulse oximeter was delivered on June 5, 2007. On May 31, 2007, Licensee documented on a 24 hour nurses report that a resident's oxygen saturation was between 93-97%. When asked regarding the discrepancy, Licensee stated that she noted the oxygen saturation range of 93-97% based on other 24 reports for the resident. As a result of the incident, Licensee was terminated.	7/4/2008 to 7/4/2009
Belinda C Karney Columbia MO	RN084757	On September 24, 2007, Licensee submitted to a urine drug screening test. The urine sample submitted tested positive for marijuana. Marijuana is a controlled substance.	7/8/2008 to 7/8/2010
Dawn R Kellenberger Dupou IL	RN149658	Licensee's supervisor discovered discrepancies in Licensee's charts. The supervisor found that Licensee was not wasting narcotics properly and had not recorded the waste. In addition, the supervisor found that Licensee took narcotics out of the Pyxis for two patients that were not assigned to Licensee and found documentation issues for five other patients regarding assessment of pain and medication administration. Licensee was confronted and stated that she could not explain the discrepancies.	7/4/2008 to 7/4/2009
Diana K Kritzer Fulton MO	RN079630	The facility stated that Licensee was terminated for falsification of documentation on patient's records. Licensee's nursing supervisor reported that she looked into records and found that Licensee showed a pattern of pre-charting. Licensee admitted to pre-charting and realized that it was against hospital policy.	6/16/2008 to 6/16/2010
Lindsey Leah Law Pueblo CO	PN2006026256	On September 12, 2006, a nurse aide advised Licensee that a resident was anxious and removing her clothing. Licensee gave the nurse aide permission to use the gait belt to restrain the resident in a chair and for her not to tell anyone. The resident was restrained by the gait belt for approximately 20-30 minutes. Licensee failed to contact the physician or the Director of Nursing prior to giving permission to use the gait belt. Licensee failed to document in the resident's chart that a gait belt was used. The resident did not have a physician order for the restraint. Licensee was terminated on September 19, 2006 as a result of her conduct.	6/28/2008 to 6/28/2009

Probation continued on page 17

Probation continued from page 16

Name	License Number	Violation	Effective Dates of Probation
Sherry R Lerma Malden MO	PN058823	On September 24, 2004, Licensee documented giving Ativan to resident V.S. at 12pm and then changed the record to 4pm without correctly documenting the error. On September 28, 2004, Licensee failed to administer insulin to resident K.M. at the time it was prescribed. The medication was later administered by another nurse. On September 28, 2004, medical charts for residents O.F., C.W., and H.B. indicated that Licensee administered medications at 12pm, after Licensee had already clocked out.	6/28/2008 to 6/28/2009
Brenda E Maupin Blue Springs MO	RN107563	On May 5-16, 2003, Licensee diverted Fentanyl. Licensee misappropriated the Fentanyl by administering the prescribed doses to her patient, and then taking home the waste. On May 3, 2005, Licensee knowingly and intentionally misappropriated Propofol. Licensee's employment was terminated on May 15, 2005.	6/16/2008 to 6/16/2013
Angela Dawn McGill Raymore MO	RN2001017794	On August 1, 2005, Licensee made a self-report to the Board that she had tested positive for Marijuana on a pre-employment drug screen.	8/13/2008 to 8/13/2009
Susan A Moseffi Saint Louis MO	RN110948	On February 15, 2007, Licensee signed and thereby agreed to enter into a Joint Stipulation with the State Board of Nursing. Following the Administrative Hearing Commission's Review, the Joint Stipulation became effective March 26, 2008. Licensee was required to call an 800 number every day to determine if she had been selected for a random urine drug screen. On multiple occasions, Licensee failed to call the 800 number.	6/12/2008 to 6/12/2011
Tracy M Novel Saint Louis MO	RN155936	On October 9, 2007 the Missouri Board of Nursing received a complaint stating that Licensee was having an inappropriate relationship with a resident. An investigation into the matter found several witnesses who stated that they observed inappropriate behavior between Licensee and the resident. Licensee resigned from the facility.	7/23/2008 to 7/23/2009
Nicki J Olvera Shawnee Mission KS	RN108334	On January 7, 2005, Licensee signed out fifty (50) milligrams of Demerol on the MAR and narcotics sheets for a patient. Licensee diverted the Demerol for her personal use. On January 8, 2005, Licensee signed out fifty (50) milligrams of Demerol on the facility's MAR and narcotics sheets. Licensee did not administer the Demerol as directed. Licensee diverted the Demerol to her personal use. Later on January 8, 2005, Licensee again signed out fifty (50) milligrams of Demerol on the facility's MAR and narcotics sheet. Licensee did not administer the Demerol. Licensee diverted the Demerol and proceeded to inject herself with it in the restroom while on active nursing duty. Licensee continued to practice nursing while under the influence of Demerol. On January 9, 2005, Licensee's urine sample tested positive for opiates. On May 14, 2003, Licensee was convicted of driving while intoxicated on February 20, 2003. On May 14, 2003, Licensee was convicted of driving while intoxicated on February 27, 2003.	6/16/2008 to 6/16/2010
Cheryl L Phipps Shell Knob MO	RN145491	On June 15, 2007, Licensee had an OB patient on Pitocin to help initiate labor. Licensee allowed the patient to walk around for ten minutes with no monitoring by a nurse. Licensee asked two technicians to watch the patients while Licensee went out to take a smoking break and told the two technicians not to tell anyone that she had left the premises and if anyone inquired as to where Licensee was to tell them that she was in the bathroom or getting something to eat. Licensee took three smoking breaks. Licensee did not clock out when she went out for her smoking breaks. Licensee was the only nurse in the OB on June 15, 2007 and the patient who was on Pitocin had to be monitored by a nurse at all times. Due to the incident, Licensee was terminated on June 22, 2007.	7/23/2008 to 7/23/2010
Adrienne Francine Piatt Salem MO	PN2008022854	On May 27, 1986, Licensee pled guilty to the Class C Felony of Possession of Cocaine in the Circuit Court of Lincoln County, Missouri. On November 1, 1999, Licensee pled guilty to the Class C Felony of Possession of Methamphetamine in the Circuit Court of Maries County, Missouri. Licensee was granted parole after receiving treatment in the Department of Corrections. That parole was revoked and she was returned to the Department of Corrections after she was arrested for Driving While Intoxicated on May 25, 2000. Licensee was successfully discharged from parole in January 2007.	7/23/2008 to 7/23/2011
Timothy W Redford Parkville MO	PN054842	On July 12, 2004, Licensee was asked to submit to both a urine drug screen, which tested positive for the presence of marijuana and to a hair specimen drug screen, which tested positive of the presence of cocaine.	6/16/2008 to 6/16/2013
Stephanie Ann Rucker Lake Saint Louis MO	RN2005007834	On August 28, 2007, a correctional officer began monitoring phone calls between an inmate at the Correctional Medical Center and the inmate's sister. During the investigation, it was discovered that Licensee and an inmate were having an inappropriate relationship. The Licensee and inmate were writing letters to one another and used the sister's inmate as a go between. Licensee admitted to having an inappropriate relationship with the inmate however she stated that she did not have a sexual or physical relationship with the inmate. Due to the incident, Licensee was terminated.	8/12/2008 to 8/12/2009
Jill A Schmid Saint Louis MO	RN146086	Licensee admitted that she had been misappropriating Morphine and Dilaudid. Licensee also reported consuming Oxycontin in October 2006.	7/5/2008 to 7/5/2013

Number of Nurses Currently Licensed in the State of Missouri

As of September 18, 2008

Profession	Number
Licensed Practical Nurse	23,167
Registered Professional Nurse	90,086
Total	113,253

Probation continued on page 18

Probation continued from page 17

Name	License Number	Violation	Effective Dates of Probation
Kathy Lynne Shelton Locust Grove OK	RN120475	On July 29, 2007, Licensee removed multiple doses of Meperidine from the Pyxis. Licensee only documented on the MAR that she had given one dose of the medication. Also on July 29, 2007, Licensee removed two doses of Morphine Sulfate. There was no documentation that either dose was given to the patient. It was documented on the patient's MAR that the drug was discontinued on July 28, 2007. Licensee was terminated on August 1, 2007.	6/12/2008 to 6/12/2011
Rhonda R Smith Macon MO	RN083374	Licensee agreed to a contract to become a foster parent in 1997. According to both state and federal guidelines, a requirement for being a foster parent was to complete the Department of Health Medication Administration training. Licensee was exempt from that requirement since at the time she became a foster parent, licensee had a Missouri license as a registered professional nurse. Licensee signed contracts indicating that she had a license as a registered professional nurse in Missouri. On February 20, 2003, based on Licensee being a registered professional nurse, Licensee contracted to become a "community support nurse" as part of the Community RN Program which included an increase in Licensee's Individual Supported Living budget. On July 14, 2005, the agency requested Licensee produce a copy of her nursing license. Licensee faxed two copies of her license. The "valid through date" on the first copy could not be read. The "valid through date" on the second copy reflected a date of 04/08, and was accompanied with a hand written note from Licensee stated, "the date is 04/08." Upon contacting the Missouri State Board of Nursing, the agency learned that Licensee's license had lapsed as of April, 2001. Licensee admitted to forging the "valid through date" on her license when she faxed a copy of her license. Licensee renewed her Missouri license as a registered professional nurse on July 18, 2005. Licensee misrepresented that she had a Missouri license as a registered professional nurse and practiced nursing from April 2001 to July 2005.	7/4/2008 to 7/4/2009

Probation continued on page 19

Probation continued from page 18

Name	License Number	Violation	Effective Dates of Probation
Robyn M Snell Kansas City MO	PN049313	On April 18, 2005, Licensee was observed to be sleeping while on duty in an examination room at a hospital. On April 20, 2005, Licensee was observed to have fallen asleep in a patient room while the patient and his wife were talking with Licensee. On June 1, 2005, Licensee appeared to have fallen asleep during a conversation with another member of the hospital staff regarding a patient matter. On June 1, 2005, while discussing her behavior with the Director of Human Resources at the hospital, Licensee's eyes were glassy, she had a delayed response and appeared to have difficulty keeping her eyes open. As a result of her suspicious behavior, Licensee was asked to submit to a "for cause" urine drug screen. Licensee failed to submit to the drug screen. On June 3, 2005, Licensee was terminated for her failure to submit to a "for cause" urine drug screen.	7/8/2008 to 7/8/2009
Patricia A Stapf Webster Groves MO	RN101896	On January 8, 2007, the manager of labor relations at the facility, was contacted by the nurse manager of the PICU unit, who told the manager of labor relations that she was concerned about Licensee in regards to the Omnicell report that she received for November of 2006. Licensee had a large amount of dispenses compared to other co-workers specifically Licensee was not scanning the medication and there was medication that was unaccounted for. The two drugs that were primarily unaccounted for were Morphine and Midazolam. The nurse manager of the PICU unit stated that most of the medication was not recorded at all and the ones that were recorded the wasting of the medication was not recorded. The nurse manager also stated that out of 45 medications pulled by Licensee from the Omnicell (in November), 31 of them were either not charted or not wasted appropriately. A meeting was held regarding the allegations on January 8, 2007 and Licensee was suspended until further investigation. For the investigation the Omnicell reports for September through December of 2007 were pulled and they showed that Licensee had a high percentage of discrepancies. Due to the results of the investigation Licensee was terminated on January 23, 2007.	7/4/2008 to 7/4/2009
Karen K Townsend Ballwin MO	RN2006022225	On December 12, 2006, the pharmacy at the facility notified the director of surgical services that an audit showed an unusually large amount of narcotics withdrawn by Licensee, without being charted in patient records. Specifically there was a large amount of Fentanyl missing from the previous day. Licensee was asked to submit to a drug test. Licensee agreed to take a drug test and on the way to the testing, Licensee admitted to misappropriating the Fentanyl for her personal consumption and asked for help with her substance abuse problem. On December 13, 2006, Licensee submitted to a drug screen which tested positive for Fentanyl.	7/8/2008 to 7/8/2011
Katheleen Watson Eolia MO	PN014385	On December 21, 2006, it was noticed by a certified nurse aide that a 93 year old resident had "severe bruising on her arm." The certified nurse aide questioned the resident about the bruising; the resident stated that a nurse had been rough with her therefore an internal investigation was launched. It was discovered that the resident had gone to the other side of the facility to pray in a quiet area, Licensee approached her and wanted to take the resident back to the infirmary. The resident stated that she refused to go and at that point Licensee grabbed her by her arms and tried to pick her up pulling the chair that she was sitting on with her. Licensee stated that she in fact did pick the resident back up to return her to the infirmary however stated that she picked the resident up under her arms. Due to the incident, Licensee was terminated from her employment on December 22, 2006.	7/4/2008 to 7/4/2009
Janice Lynn Weikal Lees Summit MO	PN2001022455	Licensee was working with a patient who was terminally ill and was receiving hospice care. The patient's doctor had written an order on March 10, 2007 for Roxanol to be given for a period of one week. Licensee administered six doses of Roxanol after the order for Roxanol had expired. Licensee either did not check the patient's orders before administering the Roxanol or ignored the doctor's orders. Licensee did not chart the dosages of Roxanol on the Medication Administration Report.	8/16/2008 to 8/22/2008
Jill S Wohletz Lees Summit MO	RN2005025842	Licensee was terminated for diversion of Dilaudid. Pyxis reports indicated that Licensee withdrew amounts of Dilaudid that were unaccounted for. Licensee initially denied diverting however she later admitted that she had been diverting Dilaudid for her personal use due to back pain.	7/23/2008 to 7/23/2013

Disciplinary Actions continued on page 20

Disciplinary Action continued from page 19

REVOCATION

Name	License Number	Violation	Effective Dates of Revocation
Catherine Ann Bain Saint Joseph MO	PN2002005146	Licensee failed to assist a choking patient.	6/13/2008
Kellie M Ballwin Hoekstra MO	PN053593	Licensee violated the terms of her probation by failing to submit completion of a chemical dependency evaluation to the Board; failing to submit employer evaluations to the Board; failing to call into NCPS, Inc. and failing to report for UDS when requested.	6/13/2008
Penny A Banks Wheat Ridge CO	PN053405	Licensee was terminated for verbally abusing residents of a long-term care facility.	6/13/2008
Michael F Bynog Hazelwood MO	RN152651	Licensee failed to report criminal history on his Louisiana licensure application. Licensee failed to closely monitor a patient in his care at Haven Meadows Care Center. The patient was found 40 minutes later away from the facility, on another residential street in the yard of a private residence. Further, Licensee misappropriated a card of 30 hydrocodone tablets from Northview Village.	6/13/2008
Pati A Byrne St Joseph MO	RN066644	Licensee violated the terms of her probation by failing to contract with NCPS, Inc.; failing to submit a Mental Health and Chemical Dependency Evaluation to the Board and failing to meet with representatives of the Board.	6/13/2008
Angela D Grider Savannah MO	PN045545	Licensee violated the terms of her probation by failing to call NCPS, Inc.; failing to do UDS as requested and for testing positive to marijuana.	6/13/2008
Dawn M Lentz St Charles MO	RN110453	Licensee violated the terms of her probation by failing to call NCPS, Inc and relapsing on fioricet.	6/13/2008
Jennifer Nicole Loggans Saint Charles MO	PN2000154524	Licensee violated the terms of her probation by failing to call NCPS, Inc.; failing to submit employer evaluations and failing to submit proof of support group attendance.	6/13/2008
Yolanda Rena Miller Saint Louis MO	PN2002001372	Licensee was terminated from Friendship Village for writing herself a check on a resident's account.	6/13/2008
Diana Marie Mohr East Alton IL	RN2005010032	Licensee violated the terms of her probation by failing to call NCPS, Inc.; by failing to report for UDS when requested; and for failing to notify her physician that she was chemically dependent.	6/13/2008
Annie L Singletary Payne Saint Louis MO	RN032819	Licensee violated the terms of her settlement agreement by failing to meet with a representative of the Board.	7/23/2008
Mary Nicole Romans Moody MO	PN2001024087	Licensee violated the terms of her probation by failing to meet with representatives of the Board.	6/13/2008
Geanne M Ruckman Pierce City MO	PN049273	Licensee violated the terms of her probation by failing to contract timely with NCPS, Inc. Then after activating her NCPS, Inc. account, failed to call as directed. Licensee also failed to submit a chemical dependency evaluation form to the Board as requested.	6/13/2008
Michelle J Cheatem Thornton Kansas City MO	RN122754	Licensee violated the terms of her probation by failing to abstain from the use of alcohol. Licensee tested positive for alcohol on February 26, 2008 and March 6, 2008.	6/13/2008
Thomas D Tosson Liberty MO	PN042736	Licensee violated the terms of his probation by failing to call NCPS, Inc. as requested; failing to submit to UDS when requested on December 6, 2007 and December 18, 2007 and failing to abstain from alcohol. Licensee tested positive for alcohol on 23, 2008.	6/13/2008
Pamela J Trotter Doniphan MO	RN117236	Licensee violated the terms of her probation by failing to contract with NCPS, Inc., failing to submit a chemical dependency evaluation to the Board and for failing to meet with representatives of the Board as requested.	6/13/2008
Bettye P Vaughn Kansas City MO	PN008120	Licensee was terminated for verbal abuse of patients.	6/13/2008
Cheryl A Woodley Columbia MO	RN2001015713	Licensee violated the terms of her probation by failing to abstain from alcohol. Licensee tested positive for alcohol on September 6, 2007 and January 25, 2008.	6/13/2008
Janet Lee Wooldridge Saint Peters MO	PN025670	Licensee violated the terms of her probation by failing to submit proof of completion of CEU's.	6/13/2008

Disciplinary Actions continued on page 21

Disciplinary Action continued from page 20

SUSPENSION/PROBATION

Name	License Number	Violation	Effective Dates of Suspension/Probation
Cheryl Ann Johnson House Springs MO	RN126276	Licensee was required to cause a letter of ongoing treatment evaluation from a chemical dependency professional to be submitted to the Board at times to be determined by the Board. The Board did not receive a letter of ongoing treatment evaluation from a chemical dependency professional on behalf of the Licensee by the January 7, 2008 due date. The Board received a letter of ongoing treatment evaluation on behalf of the Licensee on January 30, 2008. The Substance Abuse Counselor stated that Licensee had been unable to participate in treatment due to ongoing health issues. Licensee was required to submit employer evaluations from each and every employer. If Licensee was unemployed, a notarized statement indicating the dates of unemployment was to be submitted in lieu of employer evaluations. The Board did not receive an employer evaluation or a statement of unemployment by the January 7, 2008 due date. Licensee was required to inform any professional preparing a prescription for her that she is chemically dependent. On October 18, 2007, the Board received a Prescription Identification Form, the form indicated that Licensee had never advised physician that she was chemically dependent.	Suspension 6/16/2008 to 6/16/2009 Probation 6/17/2009 to 6/17/2014
Donna Nellene Brown Alton MO	PN2004003376	Licensee was required to obtain at least fifteen (15) continuing education contact hours in Nursing Law and Ethics. Licensee was to submit proof of completion of continuing education programs to the Board during the disciplinary period. The Board did not receive proof of any completed hours.	Suspension 6/16/2008 to 12/16/2008 Probation 12/17/2008 to 12/17/2009

VOLUNTARY SURRENDER

Name	License Number	Violation	Effective Dates of Voluntary Surrender
Kimberly S Kennon Cape Girardeau MO	RN103388	Licensee voluntarily surrendered her license.	7/9/2008
Garrett Alan Kohnz Lansing KS	RN2005036153	Licensee pled guilty March 21, 2007, to DWI/Involuntary Manslaughter and Failure to Stop and render aid to an injured party.	7/4/2008
Carol C McCord Sedalia MO	PN029650	Licensee was placed on the Employee Disqualification List for being physically and verbally abusive to patients.	7/23/2008
Tosha Nicole Porter Kansas City MO	PN2006015831	Licensee was terminated for inappropriate conduct regarding seven prescription refills for hydrodone called in by her mother, between January 15 and February 26, 2007. Ms. Porter filled these prescriptions and stated she had not seen the physician as a patient to receive the prescriptions.	7/4/2008
Norbert T Wieberg Mexico MO	PN045320	Licensee was put on the Employer Disqualification List for being verbally abusive and being rough with patients.	7/23/2008

Did you know you are required to notify the Board if you change your name or address?

Missouri Code of State Regulation [(20 CSR 2200-4.020 (14)(b) (1)] says in part “If a change of name has occurred since the issuance of the current license, the licensee must notify the board of the name change in writing . . .” and (2) If a change of address has occurred since the issuance of the current license, the licensee must notify the board of the address change . . .”

Note: change of address forms submitted to the post office will not ensure a change of address with the Board office. Please notify the board office directly of any changes.

Type or print your change information on the form below and submit to the Board Office by fax or mail. Name and/or address changes require a written, signed submission. Please submit your change(s) by:

- Fax: 573-751-6745 or 573-751-0075 or
- Mail: Missouri State Board of Nursing, P O Box 656, Jefferson City, MO 65102

Please complete all fields to ensure proper identification.		
<input type="checkbox"/> RN <input type="checkbox"/> LPN		
Missouri License Number		
Date of Birth		
Social Security Number		
Daytime Phone Number		
OLD INFORMATION (please print):		
First Name	Last Name	
Address		
City	State	Zip Code
NEW INFORMATION (please print)		
First Name	Last Name	
Address (if your address is a PO Box , you must also provide a street address):		
City	State	Zip Code
Signature (required)		
Date		

Duplicate license instructions:

It is not mandatory that you obtain a duplicate license. You may practice nursing in Missouri as long as your Missouri nursing license is current and valid. If you wish to request a duplicate license reflecting your new name, you must return ALL current evidence of licensure and the required fee of \$15.00 for processing a duplicate license.

Return this completed form to: Missouri State Board of Nursing, P O Box 656, Jefferson City, MO 65102

Is Your License Lost or Has It Been Stolen?

If you would like to obtain a duplicate license because your license has been lost or stolen. Please contact our office and request an Affidavit for Duplicate License form or you may obtain it from the *Licensure Information & Forms* tab on our website at <http://pr.mo.gov/nursing.asp>