Message from the President

Anne Heyen, DNP, RN, CNE

Hello and welcome, my name is Anne Heyen and it is my honor and privilege to serve you as President of the Missouri State Board of Nursing. I was originally appointed to the board in 2015 and spent the last year as the Vice President. The tremendous amount I learned while serving on the board is thanks to the fellow board members and past presidents who are still serving on the board, along with the exceptional Executive Director and other board staff. The majority of my professional career has been spent in nursing education. I taught in an associate degree program and more recently a baccalaureate degree program. The mission of the Board is to provide public protection through the regulation of nursing education, licensure and practice. I look forward to the opportunity to serve in support of this mission.

In addition to myself being elected President of the Board, Mariea Snell, DNP, MSN, RN, FNP-BC was elected Vice President and Bonny Kehm, PhD, RN, was elected Secretary of the Board. Dr. Snell is the coordinator of the Doctor of Nursing Practice program for Maryville University. In addition to her faculty and administrative role, she practices as a Family Nurse Practitioner for Peoples Health Centers in St. Louis. She holds a doctorate in nursing from St. Louis University, a master’s of science in nursing from Indiana State with a concentration in family practice and a bachelor’s in nursing from Barnes Jewish College of Nursing at Washington University Medical Center. Dr. Snell has extensive experience in research, education and community health. She has a passion for working with the underserved and embarked on her nursing career to reach groups that need care the most. She has been on the board since February 2013. Dr. Kehm is the Faculty Program Director in the baccalaureate and Master of Science programs for the School of Nursing at Excelsior College, where she designs curriculum and research. Dr. Kehm earned her bachelor’s and master’s degrees in nursing from Webster University, her doctorate in nursing education from Capella University, and her graduate certificate in Health Care Informatics from Excelsior College. Dr. Kehm has worked to improve nursing curriculum, expand opportunities for graduate nurses to transition from the clinical setting to academia and instill leadership skills in the science and art of nursing. Dr. Kehm’s commitment to improving the nursing profession includes work to increase awareness of interprofessional education opportunities that link nursing, nutrition, and health sciences education to improve interdisciplinary learning. Her research has been supported by The Robert E. Kinsinger Institute for Nursing Excellence and Sigma Theta Tau Kappa At-Large grant. She has also been honored as a speaker at the Royal College of Nursing Centennial International Conference in England. She has served on the NLN Foundation Scholarships Selection Committee, Elsevier Education Advisory Board, and as an NLN Ambassador. Dr. Kehm was recipient of the Missouri Organization of Nursing Leaders 2016 Rising Nurse Leader Award. She has been on the board since October 2017.

Executive Director Report

Lori Scheidt, MBA-HCM

Licensed Practical Nurses Licenses Set to Renew in March 2018 – Act Now!

Licensed Practical Nurse (LPN) renewal postcards with PIN numbers will be mailed in early March 2018. The postcard is mailed to the address we have on our records, so it is very important that you inform our office in writing whenever you change addresses. A change form can be found on the board’s website and also in this publication. You have a legal responsibility to change your name and/or address within 30 days of the change. Failure to inform the board of your current residence is cause for publication. You have a legal responsibility to change your name and/or address within 30 days of the change. Failure to inform the board of your current residence is cause for license discipline.

Before you renew, you need to go to www.nursys.com and enroll yourself as a Nurse in e-Notify. If you enroll now, you will decrease the amount of time it will take you to renew your license. When you submit a license renewal, your license is not automatically renewed. It takes 3-5 business days for your license renewal to be processed. If you are enrolled in Nursys e-Notify as a nurse, you will receive a notification when your license is renewed.

Protecting Your License

Protecting your license from potential fraud or identity theft should be a priority for you, especially now as Missouri enters the enhanced Nurse Licensure Compact (eNLC). One of the best ways to safeguard your license is to enroll in the National Council of State Boards of Nursing’s (NCSBN’s) Nursys e-Notify®.

Unlocking Access to Nursing Care Across the Nation

The Enhanced Nurse Licensure Compact (eNLC) is a new era of nursing licensure was ushered in on July 20, 2017, when the 26th state necessary for eNLC enactment
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

Number of Nurses Currently Licensed in the State of Missouri
As of January 2, 2018

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Practical Nurse</td>
<td>25,029</td>
</tr>
<tr>
<td>Registered Professional Nurse</td>
<td>106,677</td>
</tr>
<tr>
<td>Total</td>
<td>131,706</td>
</tr>
</tbody>
</table>

SCHEDULE OF BOARD MEETING DATES THROUGH 2018

February 28–March 2, 2018
May 23–25, 2018
August 8–10, 2018
November 7–9, 2018

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
When a nurse is terminated and the employer feels the Nurse Practice Act was violated the Board receives a complaint report. The Complaint is then investigated by the Board of Nursing’s investigative staff. As Director of Compliance for the Board of Nursing, I read some of the investigations that resulted from these complaints. I have recently read practice complaints that resulted when a nurse did not follow a basic nursing skill that would have been taught early on in nursing studies and reinforced throughout the curriculum what I refer to as “Nursing 101.”

This past month I read a couple of complaints that resulted in a licensee being terminated from their first nursing job. In these situations the licensee had only been licensed as a nurse for approximately six months. I have read complaints in the past of a new nurse not fitting in with the culture or choosing a job that she is unable to keep up with because she lacks experience. These complaints concerned me because in both of these complaints the licensee didn’t follow what they learned in “Nursing 101.”

In one instance it was difficult to determine what care the nurse provided because she did not document an assessment and did not document any of the interventions that she performed. In this situation a video did provide proof that she entered the room hourly, however it is unknown what she did in the room because she did not document if she was obtaining labs, assessing the patient or simply walking in and out of the room. Unfortunately she had a change in condition that the nurse did not detect and the facility felt due to the lack of documentation the nurse neglected the patient. Documentation is taught in “Nursing 101.” It is an essential part of what a nurse does and “if it is not documented then it is not done!”

In another instance a new licensee seemed to be disassociated from the patients. The licensee was checking her cell phone for texts and voice messages, on the computer on non-work related websites, not answering call lights, and taking over an hour to give a patient a pain medication. Family described the nurse as unprofessional and like she did not care about the patient. In a nursing clinical situation these are all behaviors that faculty would not allow. The behaviors this new graduate demonstrated gave the facility the impression that she did not want to be a nurse to the patients and they terminated her for patient neglect. Demonstrating professional behaviors at all times is taught in “Nursing 101.” It is an essential part of what a nurse does.

Like the new licensee in the paragraph above, the more experienced nurse I read about recently was terminated for not following essential nursing care. It was reported that she was off the floor for long periods of time, giving medications late, not completing assessments and orders, and not doing patient education. I read some of the investigative report recently a more experienced nurse gave a sub-q injection in an incorrect spot causing a hematoma, and did not label IV tubing. Further, she inserted a single-state license, issued from that state regardless of whether you hold a multistate practice, as defined by state practice laws of the state in which the patient/client is located. The practice of nursing is not limited to patient care and does include all nursing and regulations of the state in which you are practicing, whether that be in person or via telehealth. The practice of nursing is not limited to patient care and does include all nursing practice, as defined by state practice laws of the state in which the patient/client is located. You have to keep in mind that your nursing practice takes place where the patient is located. If the patient is located in another state, you need to be licensed to practice in that state. A multistate license helps to facilitate that, but you must still adhere to the laws and regulations of the state in which you are practicing, whether that be in person or via telehealth. The practice of nursing is not limited to patient care and does include all nursing practice, as defined by state practice laws of the state in which the patient/client is located.

In another instance a new licensee showed what I refer to as “Nursing 101.” Many skills are taught and performed in skills labs and then brought to the clinical setting. As nurses gain experience they also gain new skills but they must also be able to correctly perform the skills taught in their basic nursing fundamental classes. In an investigative report recently a more experienced nurse gave a sub-q injection in an incorrect spot causing a hematoma, and did not label IV tubing. Further, she inserted a catheter and notified the attending physician that she was concerned that the patient was not getting urine return, but did inflate the balloon causing trauma to the urethra. The skills that were done incorrectly were all “Nursing 101” skills. It is important to maintain or review the “old” skills to maintain competency as we progress in our careers.

Each nursing job is full of what we learned in school, what I call “Nursing 101.” Many skills are taught and performed in skills labs and then brought to the clinical setting. As nurses gain experience they also gain new skills but they must also be able to correctly perform the skills taught in their basic nursing fundamental classes. In an investigative report recently a more experienced nurse gave a sub-q injection in an incorrect spot causing a hematoma, and did not label IV tubing. Further, she inserted a catheter and notified the attending physician that she was concerned that the patient was not getting urine return, but did inflate the balloon causing trauma to the urethra. The skills that were done incorrectly were all “Nursing 101” skills. It is important to maintain or review the “old” skills to maintain competency as we progress in our careers. We invest in experienced nurses to ensure excellent and quality patient care. Now hiring for all areas.

Contact Kelly Herberholt
kelly.herberholt@corizonhealth.com | (314) 919-9536
The Many Lanes of APRN Roles and Populations

Kathy Hoebelheinrich, MSN, APRN-NP, ANP-BC, BC-ADM, CDE
Nursing Practice Consultant, NBON

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The National Council of State Boards of Nursing (NCSBN) hosts an annual Roundtable for Advanced Practice Registered Nurse (APRN) stakeholders to discuss common issues and concerns regarding APRNs. Invitations to the 2017 meeting included nursing regulators, educators, professional societies, credentialing agencies and others interested in the grassroots work of moving toward unified elements of the 2008 Consensus Model for APRN Regulation (Figure 1).

The theme of 2017 Roundtable, The Many Lanes of APRN Roles and Populations, aptly embodied the current tempo of inquiries to nursing regulators regarding the alignment of APRN education and certification when the focus of practice shifts beyond role and population focus.

Advanced practice nurses commit to a specific APRN role and patient population early in the course of education and training. Board certification is the driving lane for practice. Successful completion of a certification examination provides a psychometric assessment of baseline competency for entry into practice for a particular role and population. Nebraska is among those states that require board certification for licensure in order to practice as an APRN. Licensure is permission to drive within a defined statutory scope of practice.

Advanced Practice Registered Nurse specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus, e.g., a Certified Registered Nurse Anesthetist (CRNA) could specialize in pain management; a Certified Nurse-Midwife (CNM) could specialize in the care of postmenopausal women, a Clinical Nurse Specialist (CNS) could specialize in palliative care, or, the Nurse Practitioner (NP) could specialize in Hematology-Oncology.

Lane drift or lane change?
Lane drift can occur when the APRN becomes distracted by patient or other circumstances in the practice environment. Lane changes are more significant changes in practice by patient or other circumstances in the practice environment. The patient anticipates establishing and relocation for employment in another city within the next 12 months.

- The PNP is offered a case management position which includes additional responsibilities for hospital rounds for the Hematology-Oncology practice to assist established clinic patients and their families in the discharge transition to home and clinic-based care.
- The PNP is informed that clinic NPs will now be required to rotate evening and week-end call for the Hematology-Oncology practice. Call will include new hospital patient referrals.

Misalignment
Misalignment of APRN practice and credentials can manifest on several fronts:

1. Payer requirements for APRN credentials for reimbursement of services, e.g., behavioral health or primary care
2. A plaintiff attorney requests a clinician/practice/facility to provide evidence for the qualifications of an APRN provider
3. Employers and/or medical credentialing staff do not understand APRN credentials
4. Providers make referrals for specialty practice consultations expecting a physician
5. Patients may not be fully informed regarding the qualifications of APRN providers
6. APRNs fail to recognize employment opportunities that are not safe practice

(Buppert, 2017).

Defensible Practice
According to Buppert, (2017) notwithstanding the patient safety and outcomes are always front and center, APRNs accepting employment misaligned with education and certification must also take deliberate action to make practice defensible. Tarn signal on… adjust speed, check mirrors and identify the blind spots! Defensible practice is essentially defined and measurable competencies.

- Competency in specialty areas is acquired through additional education, training and experience.
- Competency can be assessed in a variety of ways through professional credentialing mechanisms, e.g., examination, portfolio or peer review.
- Additional certification in a new specialty area of practice is strongly recommended.

When certification in a particular specialty is not available to APRNs, it may be necessary to identify other alternatives e.g., an immersion course or number of observed procedures. Similarly, be alert to potential pitfalls when training for new devices, products or procedures is accessed through vendors with limited or no means to validate competency.

First-time and new APRN employees should ascertain that orientation, onboarding and training protocols meet personal needs to establish safe and effective practice. Preceptorships and fellowships may be appropriate.

Practice should be consistent, retrievable and reproducible whenever possible, including informed adherence to professional guidelines and standards of care. Development and compliance with employer or practice policies and procedures is also important.

The health care needs of the patient, not the practice setting dictate the qualifications and competencies of the APRN. The APRN should have the knowledge to differentially diagnose and manage the conditions likely to be encountered.

It may be necessary to secure formal relationships and identify mechanisms for the accessibility and on-site availability of other providers.

In summary, APRNs commit early in the course of education and training to a particular role and population focus. Practice lanes are affirmed with professional credentialing and subsequent licensure. Lane changes are best preceded with planning for the acquisition of new competencies and other means for defensible practice.

Advanced practice nurses must necessarily assume responsibility for recognizing practice opportunities that may be misaligned with education and certification, and ultimately present risks to patient safety and outcomes.

References:
WHAT COULD HAPPEN: The Consequences of “Practice Drift” ...Is It Worth the Risk?

Kathy Chastain, MN, RN, FNE and Linda Burhans, PhD, RN, FNE

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PURPOSE & OBJECTIVES

To assist nurses in understanding and identifying practice drift and how to eliminate/mitigate effects.

Objectives:
1. Explain “practice drift.”
2. Recognize factors that contribute to the occurrence of “practice drift.”
3. Assess the impact of “practice drift.”
4. Create a plan to eliminate and decrease “practice drift.”

Have you ever...

1) Deviated from the procedure for safe medication administration...
   • administered a medication prior to obtaining an order from a provider because you “knew” what the pharmacist would order;
   • borrowed a medication from another patient or used STAT orders to override the system as a workaround to bypass slow pharmacy services;
   • administered a pain medication without completing a pain assessment because you were in a hurry;
   • prepared medications simultaneously for more than one patient because you were pressed for time and/or you were trying to save a few steps;
   • carried medications in your pocket and wasted them at the end of the shift because there wasn’t anyone available at the time to be a witness;
   • signed as a witness to a narcotic medication waste you did not observe because you trusted your co-worker;
   • left a patient’s medications on the bedside table because he/she was on the phone;
   • failed to check 2 identifiers when administering medication because you were in a rush;
   • failed to scan the bar code on a medication because the scanner wasn’t working;
   • made assumptions when orders were incomplete or were illegible because you didn’t want to bother the provider; or
   • hidden away unused medications from discharged patients for administration to other patients if needed in the future to avoid delays.
2) Neglected a patient?
   • failed to perform an assessment or treatment when an appropriate time to do so would be appropriate;
   • silenced a piece of equipment (bed alarm, IV pump, cardiac monitor, etc.) because it kept alarming for an apparent reason and you felt it was disturbing the patients; or
   • failed to complete the “time out” in surgery because the surgeon was upset with how long it took to set up for his/her patient;
3) Failed to maintain an accurate patient medical record?
   • pre-documented an assessment or care delivered to save time because the information was always the same;
   • pre-documented medication administration information you knew you would not have time later; or
   • waited until the end of the shift to document all assessments and care rendered because you didn’t have time during the shift to get it done.
4) Breached a patient’s confidentiality?
   • out of curiosity, looked up information on a patient you were not assigned to provide care;
   • posted pictures or comments about patients or their care on social media;
   • discussed patient information in a public setting (e.g., elevator or cafeteria) or commented on a patient’s condition to another patient or family member.
5) Exceeded scope of nursing practice?
   • acted outside your scope of practice by writing “verbal orders” without actually speaking with the provider, believing they would be signed off at next rounds; or,
   • performed a procedure that was outside your scope of practice (e.g., rupturing membranes to induce labor) because the provider instructed you to do so.

Consider the following scenario:
Megan, a newly-employed Registered Nurse in the Operating Room of a small rural hospital, was assigned to circulate with another...

STOP READING: Go back to your “practice drift” list. For each variation, list the reason(s) for those variations. Why do you and your co-workers use these work-arounds and shortcuts and bend established rules? What are you trying to achieve? What problems in the system or environment make it seem necessary to use these approaches?

WHAT COULD HAPPEN continued on page 6
WHAT COULD HAPPEN continued from page 5

This example demonstrates how “practice drift” became a “cultural norm” for this facility. Based on extensive studies and the patient safety literature, this example demonstrates how “practice drift” so common that it is used routinely by all nurses. Megan voiced concerns that the procedure was taking longer than expected and “start taking his surgeries elsewhere” as there was no way to finish the set up and due to the delays they were never ready and always caused him to be behind in his schedule. The nurses rushed to finish the set up and due to the delays the experienced nurse instructed Megan that they would forgo doing the required “time out” to verify the patient, procedure, site, allergies, and antibiotics administered. Megan voiced concerns but was assured this was “common practice” for this surgeon to keep him happy as you never wanted to be on his bad side.

STOP READING: Go back to your “practice drift” list. Highlight those variations that have become “cultural norms” in your setting. Is this “practice drift” so common that it is used routinely by all nurses? Is it used only by some of the nurses? If so, why do the other nurses not use these approaches?

Dr. Van Sell (2012), noted that nurses will engage in intentional rule bending behavior to solve an immediate problem and not realize the potential negative consequences. Factors such as staffing levels, patient acuity, workload, time constraints, interruptions/ emergencies, lack of access to providers, lack of input in design of workflow and procedures, familiarity and trusting relationships with providers, and lack of proper working equipment/support among others can be some of the reasons why nurses face every day when trying to do what needs to be done to provide effective patient care.

The new resident had an order for an oral antibiotic which had not been delivered. Cindy knew who the resident was taking this same medication so she “borrowed” one dose because she didn’t have time to wait on the pharmacy. She failed to check the new resident’s allergies, thus failing to see that there was a documented allergy to the antibiotic she had administered. The resident had an allergic reaction resulting in the resident having to be transferred back to the hospital.
Instead of waiting on the pharmacy or calling to see why the resident’s medications had not been delivered, Cindy decided to bypass policy and borrow the medication from another resident. Had she called the pharmacy she would have been informed that there was a question regarding the order. This third safety mechanism would have prevented an error.

Cindy believed that pre-pouring all the medications at once would save her time and be more efficient. At a nurse’s conference she learned that she could label the baggies with room numbers only. She chose to ignore all patient safety policies and procedures.

Cindy’s decision to pre-document all the medications that were scheduled to be administered during her shift ultimately resulted in confusion as to what medications had been administered when another nurse came to assist. Notification of the supervisor resulted in an internal investigation into Cindy’s methods of administration. Cindy resigned and resulted in a report to the Board. As a result of this action, Cindy’s credibility was called into question causing her employer to question if she falsified patient records routinely.

Findings: Cindy inappropriately delegated medication administration to an unlicensed nursing assistant. This, too, was a violation reported to the Board.

Ultimately, Cindy’s actions in this shift demonstrated extreme “practice drift.” Her overall intent was to provide the best care possible with limited resources. However, the time Cindy thought she was saving by using shortcuts, bending rules, and implementing work-arounds, resulted in compromised patient care, damage to her professional reputation and credibility, a potential loss of her job, and a potential sanction of her nursing license.

It is not uncommon for any one of us, when faced with having to do more with less or when pushed for time, to find ways to use work-arounds and take shortcuts. In a busy work environment, particularly one that is understaffed, rule-bending may seem like the only solution. But none of these influence substantive change and they don’t break or bend one. Rule-bending, work-arounds, and shortcuts are all reflective of the “practice drift” used to achieve specific outcomes. They often seem like the only solution. But none of these influence substantive change and they may be used as unique, short-term solutions and the opportunities for improvement are lost.

“Practice drifts” operate as adaptations to inefficiencies and have the potential to both subvert and augment patient safety. Occasionally, work-arounds operate as long-term solutions to deficiencies in the delivery of services, places that the patient’s best interests at the forefront, operate as adaptations to inefficiencies, and provide opportunities for improvement. When operating in this manner, they are used as unique, short-term solutions and the opportunities for improvement are lost. Frequently, we fail to see that the work-arounds, and shortcuts circumvent safety blocks, mask environmental and operational deficiencies, and undermine standardization they have the potential to jeopardize patient safety as well as your career. When a patient is injured because you deviated from the standard of care, there is little defense to be found (HPSO, 2015). Rules: we can’t live without them, but there is probably not a day goes by when we don’t break or bend one. Rule-bending, work-arounds, and shortcuts are all reflective of the “practice drift” used to achieve specific outcomes. They often seem like the only solution to fixing what is wrong. They become part of the culture and the need to defend faulty practices is hidden. We often fail to see that we have institutionalized a temporary, inadequate fix. In many cases, it is not until an adverse event requires deeper examination that the underlying conditions that led to unacceptable practice are identified.

Nurses, according to the Gallup Poll, have ranked as the most trusted profession for the last 14 years (ANA, 2015). Nurses strive to do a good job and to provide safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice.
As I'm writing this, it's early December and everyone is in the holiday spirit. For us, it started on December 1 when my entire family (grandkids and all) went to New York City to do the classic Christmas tour. It also happened to be the birthday of The Hotness, so it was celebration central! As our wide-eyed throng of seven adults, one kindergartner and a three-month-old stepped out of the subway, we witnessed something disturbing: A man fighting with a light pole. True 'bare-knuckle punches on a steel streetlight while screaming obscenities at an inanimate object' kind of fight. This wasn't boxing or play fighting – it was with an intensity and strength that undoubtedly led to broken bones.

We moved the six-year-old and baby to the middle of our crowd, and carried on. Friends, there wasn't a single thing I could do to help this man. Whatever mental illness plagued him is out of my area of expertise. There are meds that could help, but I can't prescribe those and, even if I could, no one could force him to take them. This is a pretty helpless feeling… and one which, I'm sure that you, Faithful Reader, have had, too.

Had this man not been in a knock down, drag out fight with the street light, he could have passed by us undetected like the other eight million New Yorkers. But, that behavior was just too obvious. This caused me to think about an event just a few weeks before our New York trip.

In mid-November, I had the pleasure of attending the Missouri March of Dimes Nurse of the Year Awards Banquet (which happens to include several counties in Illinois as well!). Finalists in the 20 different categories were recognized and winners announced. My two favorite nurses, Barb and Jenny, were both finalists in their respective categories, but I was also excited to hear about the great work of other exceptional nurses.

The first Nurse of the Year Award was in the category of behavioral health and the winner was Dr. Mary Ann Boyd, professor emerita at Southern Illinois University-Edwardsville. In her acceptance speech, Dr. Boyd first thanked the March of Dimes for including the category of behavioral health.

I think the average lay person usually thinks of nursing in an acute care setting. Or maybe nurses working in a long-term care facility. Or maybe in a clinic. But, I don't think the average Joe on the street usually thinks of nursing in relation to behavioral health.

But, when you work in any type of healthcare, you see the challenges of mental illnesses, up close and personal. It may not be the whole reason the patient is before you, but it's often a determining aspect.

No, there was nothing I could have done to help that man on the streets of New York, it left me feeling sad and helpless… Then, I remembered Dr. Boyd's work. There IS help. It comes from nurses like Dr. Boyd. And you. As we raise awareness of the importance of behavioral health, we are taking the brain and mind into account as we have done with the visible, tangible body.

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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. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

The Board of Nursing is requesting contact from the following individuals:

- Brandi L. Findley – RN 054041
- Amanda Carla Franz – RN 2014004807
- Janet L. Hollands – RN 2000144391
- Angela Leigh King – RN 2010025942
- Tiffany Nichole Meyers – PN 2005041268
- Cassandra Lynn Wilmes – RN 201002609

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

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CENSURE

Lennon, Natalie Kay
Savannah, GA
Registered Nurse 2016033478
Licencsee submitted an application dated October 25, 2016, that indicated that she had received a “BSN” from the College of Coastal Georgia on her application. Further, Licensee submitted a fraudulent diploma purportedly issued by College of Coastal Georgia to Aureus in an attempt to be hired under the pretense of being a BSN Registered Nurse. Aureus verified Licensee’s education with College of Coastal Georgia and discovered that Licensee had received an Associates degree and not a Bachelors degree from the College and that Licensee had submitted a fraudulent diploma to Aureus. Licensee was enrolled in classes to obtain her “BSN” but had not obtained her “BSN” at that time. Licensee admitted to the Board Investigator that she had not graduated from a “BSN” program and had made the diploma herself in order to obtain a travel job with Aureus.

Censure 11/17/2017

Ellison, Cassandra Anne
Carl Junction, MO
Registered Nurse 2014040224
Licencsee misrepresented patient information by documenting assessments she had not performed and using post information. Licensee misrepresented a patient’s chart by documenting that a skin assessment had been witnessed when it had not been witnessed.

Censure 09/13/2017

Oligschlaeger, Tammy J
Mexico, MO
Registered Nurse 201507702
On or about March 1, 2016, Licensee entered the room of a minor patient to obtain a urine sample. The patient refused and eventually struck Licensee in the face. Licensee then, with the assistance of hospital security, restrained the patient without first securing a doctor’s order, although she subsequently secured such an order.

Censure 10/31/2017

Higgenston, Paula C
New Madrid, MO
Licensed Practical Nurse 2008028843
On November 14, 2016, Licensee called a pharmacy and requested a prescription for Adipex for her mother. The pharmacy technician wrote the name of the physician incorrectly, which caused the pharmacist to contact the physician who had previously written prescription for her mother. The physician advised the pharmacy to not fill that prescription, as he had not written that prescription. When questioned by medical office officials, Licensee acknowledged that she had called in the Adipex prescription for her mother. She stated she did so because her mother’s prescription had expired. Licensee did not have authorization from the prescribing physician to call in a prescription for her mother.

Censure 09/07/2017

Bernholtz, Cathy Jo
Kearney, MO
Licensed Practical Nurse 2001081835
Licensee practiced nursing in Missouri without a license from June 1, 2016 to September 26, 2017.

Censure 11/04/2017

Stanley, Cody Nathan
Dexter, MO
Licensed Practical Nurse 2015000379
Respondent failed to check in with NTS on three (3) days. Further, on December 8, 2016; June 13, 2017; June 22, 2017; and July 7, 2017, Respondent checked in with NTS and was advised that he had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on October 20, 2016, Respondent failed to check in with NTS; however, it was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on October 20, 2016. The Board did not receive an employer evaluation or statement of unemployment by the quarterly due dates of January 6, 2017 and July 6, 2017.

Censure 09/22/2017

McElfresh, Jennifer Michelle
Lake Saint Louis, MO
Registered Nurse 2005023515
On or about November 30, 2016, Licensee wrote and signed two prescriptions using the prescription pad of her supervising physician at the spa, for someone who did not receive primary care at the spa, but who was a patient at a different facility where Licensee worked that was not connected with Dr. S.I. The prescriptions were for sixty 0.5 mg alprazolam pills with three refills and for thirty 20 mg Adderall XR pills with unlimited refills. The supervising physician had not approved Licensee to write the prescriptions in question and would not have authorized Licensee to write prescriptions for alprazolam or Adderall through the spa. Pursuant to 20 CSR 2200-4.200 (3)(g)(1), any prescription written by Licensee must have the name, address, and telephone number of both the collaborating physician and the APRN on it. The prescription pad used by Licensee contained only the information of her supervising physician with her signature. Pursuant to 335.019 RSMo, Licensee is to be deemed eligible to prescribe controlled substances by the Board, and then obtain approval from the Bureau of Narcotics and Dangerous Drugs (BNDD) and the Drug Enforcement Administration (DEA) before being legally authorized to prescribe controlled substances. Licensee does not have controlled substance prescriptive authority from the Board or approval from the BNDD or DEA.

Censure 11/04/2017

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Harvey, Kelly S
Carrollton, MO
Registered Nurse 137676
Licensee practiced nursing in Missouri without a license from May 1, 2015, to April 18, 2017. Censure 09/07/2017

Chamblin, Barbara Josephine
Shawnee Mission, KS
Registered Nurse 133451
Licensee's license expired on April 30, 2015. On or about August 20, 2017, Licensee learned her license had expired and submitted a for cause drug screen. The sample which was collected on August 20, 2017, was tested and found positive for Phentermine. Phentermine is a controlled substance. Probation 09/07/2017 to 09/07/2018

Poynter, Jason Michael
Saint Louis, MO
Licensed Practical Nurse 2014022342
On July 27, 2015, Licensee pled guilty to the offense of Driving While Under the Influence of Alcohol in the Circuit Court of Fayette County, Illinois. Licensee had two (2) previous driving while intoxicated offenses in November 2007 and October 2008. Censure 10/31/2017

Kerns, Mary Ann
O Fallon, MO
Registered Nurse 128192
On December 22, 2015, Licensee documented the waste of a 2mg/ml vial of Dilaudid; however, the nurse who was documented as wasting with Licensee stated to officials that she did not recall observing the waste of the narcotic. A review of Licensee's diversion reports identified a consistently higher than normal standard deviation for Dilaudid administration by Licensee. During December 2015, Licensee withdrew Dilaudid three times and did not document the administration or waste. On December 22, 2015, Licensee withdrew Dilaudid 2 mg for patient C.B. at 7:37, however, Licensee failed to document the administration or waste of the medication. On December 22, 2015, Licensee withdrew Dilaudid 2mg for patient C.B. at 7:57, however, Licensee failed to document the administration or waste of the medication. She indicated that she had returned the Dilaudid to Pyxis, however, the Dilaudid wasn't found. On December 22, 2015, Licensee withdrew Dilaudid 4 mg and Fentanyl 110 mcg for patient N.C. at 17:23; however, she failed to document the administration or waste of 1.5 mg of Dilaudid and 100 mcg of Fentanyl. Probation 11/07/2017

Fornier, John Bruce
Poplar Bluff, MO
Registered Nurse 2009008074
Licensee was scheduled to be on-call as the nurse anesthetist from 7:00 p.m. to 3:00 a.m. on March 23, 2017. On March 23, 2017, at approximately 10:35 p.m., the hospital was notified that staff was unable to reach Licensee about a patient needing an epidural. The House Manager responded to the on-call room, where Licensee was sleeping, and knocked several times. When Licensee failed to answer the door, the House Manager opened the door with the key and entered the room. Licensee was found lying in bed with his street clothes on. The House Manager had to “bellie” at Licensee a few times and then Licensee rolled over. Licensee's speech was slurred and he was unable to sit up straight. A mostly empty bottle of spiced rum was found next to the bed. When questioned, Licensee admitted that he had been drinking alcohol and was intoxicated. On a breathalyzer test, Licensee blew .186 initially and .172 seventeen minutes later. Probation 10/13/2017 to 10/13/2022

Kennedy-Novicki, Elizabeth Marie
Grover, MO
Registered Nurse 2017032068
Licensee was previously licensed by the Missouri Board as a registered professional nurse, license number RN 2000158817. Her license was originally issued on June 19, 2000, was placed on probation by the Board on August 31, 2000, and was voluntarily surrendered on December 1, 2011, and was voluntarily surrendered on December 1, 2011. Licensee pled guilty to the class B felony of production of a controlled substance by a registered professional nurse. Probation 11/24/2017 to 11/24/2022

Fortner, John Bruce
Poplar Bluff, MO
Registered Nurse 2009008074
Licensee was scheduled to be on-call as the nurse anesthetist from 7:00 p.m. to 3:00 a.m. on March 23, 2017. On March 23, 2017, at approximately 10:35 p.m., the hospital was notified that staff was unable to reach Licensee about a patient needing an epidural. The House Manager responded to the on-call room, where Licensee was sleeping, and knocked several times. When Licensee failed to answer the door, the House Manager opened the door with the key and entered the room. Licensee was found lying in bed with his street clothes on. The House Manager had to “bellie” at Licensee a few times and then Licensee rolled over. Licensee's speech was slurred and he was unable to sit up straight. A mostly empty bottle of spiced rum was found next to the bed. When questioned, Licensee admitted that he had been drinking alcohol and was intoxicated. On a breathalyzer test, Licensee blew .186 initially and .172 seventeen minutes later. Probation 10/13/2017 to 10/13/2022

Griggs, Matthew Ryan
Kansas City, MO
Registered Nurse 2015024684
Licensee was found falling asleep at the nurse's station. When the oncoming nurse was receiving report, Licensee had slurred speech and was not steady on his feet. One of Licensee's patients was found in restraints; however, there was no documentation or an order for the restraints in the patient's chart. Licensee was asked to submit to a for cause drug screen. The sample which Licensee submitted returned positive for Marijuana and Benzodiazepines, on February 22, 2016. Licensee admitted to the Board’s investigator that he had smoked marijuana approximately one month before the incident. Further, Licensee admitted that he had taken his wife’s alprazolam for anxiety. Probation 11/24/2017 to 11/24/2022

Chamblin, Barbara Josephine
Shawnee Mission, KS
Registered Nurse 133451
Licensee’s license expired on April 30, 2015. On or about August 20, 2017, Licensee learned her license had expired and submitted a for cause drug screen. The sample which was collected on August 20, 2017, was tested and found positive for Phentermine. Phentermine is a controlled substance. Probation 09/07/2017 to 09/07/2018

Chamblin, Barbara Josephine
Shawnee Mission, KS
Registered Nurse 133451
Licensee’s license expired on April 30, 2015. On or about August 20, 2017, Licensee learned her license had expired and submitted a for cause drug screen. The sample which was collected on August 20, 2017, was tested and found positive for Phentermine. Phentermine is a controlled substance. Probation 09/07/2017 to 09/07/2018

Kennedy-Novicki, Elizabeth Marie
Grover, MO
Registered Nurse 2017032068
Licensee was previously licensed by the Missouri Board as a registered professional nurse, license number RN 2000158817. Her license was originally issued on June 19, 2000, was placed on probation by the Board on August 31, 2011, and was voluntarily surrendered on December 1, 2011. Licensee pled guilty to the class B felony of production of a controlled substance by a registered professional nurse. Probation 11/24/2017 to 11/24/2022
Missouri State Board of Nursing

February, March, April 2018

Disciplinary Actions**

PROBATION continued from page 11

a controlled substance on November 12, 2010. Licensee reports that she received treatment from January 2011-April 2011, as ordered by the court. Licensee also reports that she again received treatment from November 2012-April 2013, as ordered by the court due to testing positive for marijuana. During treatment, Licensee was diagnosed with cannabis dependence, and it was recommended that she continue recovery support and outpatient psychiatric care. Licensee received a substance abuse evaluation on April 13, 2017, which stated that no further treatment was needed. Probation 09/05/2017 to 09/05/2020

Brown, Jacqueline S
Monroe City, MO
Licensed Practical Nurse 054739
Patterson, MO
Marler, Karmen M

Accessory - Theft/Stealing.
Respondent pled guilty to the class A misdemeanor of
administration, waste, or return of the remaining 262.5 mcg of Fentanyl.
Probation 09/07/2017 to 09/07/2020

Benfield, Marilyn Rose
Bonne Terre, MO
Registered Nurse 2000158088

Further, on October 6, 2016, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on September 9, 2016, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On April 14, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. On April 20, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of October 13, 2016. Probation 09/07/2017 to 09/07/2018

Heuser, Crystal Lynn
Bolivar, MO
Registered Nurse 2010022779

On February 26, 2015, Respondent received a plan of correction from the hospital regarding documentation issues and the management of her time spent assessing patients. Respondent was taken off the plan of correction in May 2015. In August 2015, hospital officials reinstated the plan of correction for further issues exhibited by Respondent regarding reassessing acute patients and compliance in assuring medication orders were entered correctly. During an audit of narcotic administration, hospital officials discovered that Respondent had withdrawn Fentanyl 100 mcg for IVF on three separate occasions for the same patient, once on July 31, 2015 at 15:52 and twice on August 1, 2015 at 10:35 and 12:59. The dose ordered each time was 12.5 mcg. Respondent documented those doses as administered. Respondent did not document the administration, waste, or return of the remaining 262.5 mcg of Fentanyl.
Probation 09/07/2017 to 09/07/2020

Marler, Karmen M
Patterson, MO
Licensed Practical Nurse 054739

Licensee indicated that she had worked while her license was expired. Licensee reported that she worked as a licensed practical nurse from December 2, 2008, until September 22, 2016. Licensee practiced nursing in Missouri without a license from June 1, 2010, through September 22, 2016. Licensee practiced nursing in Missouri without a license from June 1, 2010, through September 22, 2016. Licensee practiced nursing in Missouri without a license from June 1, 2010, through September 22, 2016. Licensee also reports that she received treatment from January 2011-April 2011, as ordered by the court due to testing positive for marijuana. During treatment, Licensee was diagnosed with cannabis dependence, and it was recommended that she continue recovery support and outpatient psychiatric care. Licensee received a substance abuse evaluation on April 13, 2017, which stated that no further treatment was needed. Probation 09/05/2017 to 09/05/2020

Heuser, Crystal Lynn
Bolivar, MO
Registered Nurse 2010022779

On February 26, 2015, Respondent received a plan of correction from the hospital regarding documentation issues and the management of her time spent assessing patients. Respondent was taken off the plan of correction in May 2015. In August 2015, hospital officials reinstated the plan of correction for further issues exhibited by Respondent regarding reassessing acute patients and compliance in assuring medication orders were entered correctly. During an audit of narcotic administration, hospital officials discovered that Respondent had withdrawn Fentanyl 100 mcg for IVF on three separate occasions for the same patient, once on July 31, 2015 at 15:52 and twice on August 1, 2015 at 10:35 and 12:59. The dose ordered each time was 12.5 mcg. Respondent documented those doses as administered. Respondent did not document the administration, waste, or return of the remaining 262.5 mcg of Fentanyl.
Probation 09/07/2017 to 09/07/2020

Benfield, Marilyn Rose
Bonne Terre, MO
Registered Nurse 2000158088

Further, on October 6, 2016, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on September 9, 2016, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On April 14, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. On April 20, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of October 13, 2016. Probation 09/07/2017 to 09/07/2018

Heuser, Crystal Lynn
Bolivar, MO
Registered Nurse 2010022779

On February 26, 2015, Respondent received a plan of correction from the hospital regarding documentation issues and the management of her time spent assessing patients. Respondent was taken off the plan of correction in May 2015. In August 2015, hospital officials reinstated the plan of correction for further issues exhibited by Respondent regarding reassessing acute patients and compliance in assuring medication orders were entered correctly. During an audit of narcotic administration, hospital officials discovered that Respondent had withdrawn Fentanyl 100 mcg for IVF on three separate occasions for the same patient, once on July 31, 2015 at 15:52 and twice on August 1, 2015 at 10:35 and 12:59. The dose ordered each time was 12.5 mcg. Respondent documented those doses as administered. Respondent did not document the administration, waste, or return of the remaining 262.5 mcg of Fentanyl.
Probation 09/07/2017 to 09/07/2020

Benfield, Marilyn Rose
Bonne Terre, MO
Registered Nurse 2000158088

Further, on October 6, 2016, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on September 9, 2016, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On April 14, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. On April 20, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of October 13, 2016. Probation 09/07/2017 to 09/07/2018

Davis, Jamie Lea
Cole Camp, MO
Registered Nurse 2090908888

On or about February 8, 2016, the Board received a complaint regarding the nursing license of Licensee. On or about January 9, 2016, the medication room supervisor notified the Director of Nursing that there was some Strattera medication unaccounted for. As there were no patients in the facility currently taking Strattera, there was no reason for any nurse to withdraw the Strattera medication. The Medication Room Supervisor reviewed an issue on December 12, 2015, with missing Strattera. Therefore, the Medication Room Supervisor was instructed to count the Strattera medication on a daily basis. On January 11, 2016, at approximately 1030, a count was done of the Strattera. A count was again done January 12, 2016 at approximately 1030. There was one 25 mg tablet of Strattera and one 20 mg tablet of Strattera missing. A search was conducted through the medication room cameras for the period of January 11, 2016 to 1030, through January 12, 2016 at 11:00. Officials reviewed security video showing that at approximately 2135 on January 11, 2016, and 0218 on January 12, 2016, Licensee took 25 mg tablet of Strattera and one 40 mg tablet of Strattera from the medication box. On January 13, 2016, the Director of HR Administration and the Assistant Director of Nursing met with Licensee and questioned her about the missing Strattera. Licensee admitted to taking the two missing Strattera tablets for another employee, but would not name the employee. Licensee further stated that she has pulled Strattera for the other employee “May[be] a couple of times. I wouldn’t think over five times.” Probation 11/28/2017 to 11/28/2022

Paden, Charley N
Richmond, MO
Registered Nurse 2012008784

On April 6, 2017, the Board received a complaint reporting the termination of Licensee due to accepting a monetary...
gift from a client’s family member and for testing positive for marijuana. On or about March 29, 2017, Licensee was involved in a car accident after leaving a patient’s home. A routine drug screen following the car accident was positive for marijuana. In March 2017, it was reported to Phoenix administrators that a client’s family member sent Licensee a “thank you” card and $100 for appreciation of the care and assistance provided to the client. Licensee admitted to providing her home address to the client’s sister so she could send a thank you card, which violates professional boundaries.

Probation 11/28/2017 to 11/28/2022

Tomlinson, Tara Liane
Florisant, MO
Registered Nurse 2003012764
On February 26, 2016, Licensee was asked to submit to a for-cause drug screen, at which time she was suspended from the hospital, pending the results of the drug screen. The drug screen was confirmed positive for marijuana on March 3, 2016. Probation 10/13/2017 to 10/13/2020

Bruegman, Summer Danielle
Bolivar, MO
Licensed Practical Nurse 2013038545
Patient F.S. reported to the agency that Licensee had not been in her home approximately a week after July 18, 2015. Licensee documented that she visited patient F.S. in her home on or about July 23, 2015. Patient W.M., who lived in the vicinity of patient F.S., stated that Licensee had not been to his home in over a month. On July 9, 2015, July 17, 2015, and July 23, 2015, Licensee documented that she visited patient W.M. Licensee falsely documented that she had assessed the patients. Licensee’s record entry constituted falsely documenting her findings. Probation 09/29/2017 to 09/29/2019

O’Dell, Karen Nadine
Harrison, AR
Licensed Practical Nurse 2008025611
On July 6, 2015, Licensee was witnessed by coworkers going into unsanitized work areas and removing the sharps containers. On July 21, 2015, Licensee was witnessed removing a sharps container from a room and then taking the container into the biohazard disposal area for an unusually long period of time. On July 23, 2015, Licensee was questioned by the Assistant Director of Nursing of the facility regarding her behavior; she admitted that she had been removing Fentanyl patches from sharps containers and chewing on them since June 22, 2015. Probation 09/09/2017 to 09/09/2021

Brown, Karen L.
Saint Peters, MO
Registered Nurse 150353
On or about November 2, 2016, Licensee visited a patient’s home and provided care. The patient informed Licensee that he was not using some of his pain medications, so Licensee told the patient that she would take his pain medications back to the agency to be wasted. The agency’s office stating that Licensee had taken his pain medications from the home and he did not have a clear and accurate assessment of the patient’s condition. Upon returning home on November 5, 2016, the patient contacted the agency and instructed the patient’s mother to take the patient to the hospital for care related to an infection. During her visit with the patient, Licensee noted a change in the patient’s condition and informed the patient’s mother to take the patient to the hospital for care related to an infection. Upon returning home on November 5, 2016, the patient contacted the agency office stating that Licensee had taken his pain medications from the home and he did not have a clear and accurate assessment of the patient’s condition. Upon returning home on November 5, 2016, the patient contacted the agency office stating that Licensee had taken his pain medications from the home and he did not have a clear and accurate assessment of the patient’s condition. Upon returning home on November 5, 2016, the patient contacted the agency office stating that Licensee had taken his pain medications from the home and he did not have a clear and accurate assessment of the patient’s condition. Upon returning home on November 5, 2016, the patient contacted the agency office stating that Licensee had taken his pain medications from the home and he did not have a clear and accurate assessment of the patient’s condition. 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Stadler, Louis Joseph
Jenks, OK
Registered Nurse 2010008003
From May 24, 2017, until the filing of the Complaint on July 11, 2017, Respondent failed to check in with NTS on three (3) days. On June 27, 2017, Respondent reported to a collection site to provide a sample, and the sample tested positive for Ethyl Glucuronide (EOG) and Ethyl Sulfate (ESS), metabolites of alcohol. Probation 09/07/2017 to 09/07/2020

Simons, Daniel Morgan
Spokane, MO
Registered Nurse 2014021005
The audit showed that the Licensee did not properly document the administration, waste, or return of several controlled substances from April 2016 through June 2016. On multiple occasions Licensee failed to document the administration, waste, or return of fentanyl, morphine and lorazepam. Licensee failed to properly document the administration, waste, and return of multiple controlled substance medications. Accurate documentation related to medication administration is an essential function of being a nurse, as poor documentation can jeopardize patient health and safety. Licensee was asked to submit a sample for a for-cause drug screen; however, Licensee did not provide a sample for hospital officials. Licensee was terminated from the hospital on June 15, 2016, for failing to submit to a for-cause drug screen. Probation 09/20/2017 to 09/20/2022

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PROBATION continued from page 13

Bonham, Erin Renee
Bakerfield, MO
Registered Nurse 2009903627
Licensee worked as a nurse in Missouri without a license from May 1, 2017 until June 16, 2017. This is the second time that Licensee has worked without a valid license, having done so from May 1, 2011 through February 8, 2012 previously. Probation 10/05/2017 to 10/17/2017

Pearson, Dale Allen
Bloomfield, MO
Licensed Practical Nurse 2008023382
On October 11, 2016, Respondent was working at the facility as the only nurse on duty from 10:00 p.m. to 6:00 a.m. At approximately 11:45 p.m., the facility’s Director of Nursing Services was informed by facility staff that Respondent had left the building. Respondent did not return to the facility for approximately one hour. Respondent abandoned his patients for approximately one hour. On October 21, 2016, Respondent pled guilty to the class C felony of Possession of a Controlled Substance. Probation 09/07/2017 to 09/07/2022

Shy, Janet Rebekah
Desloge, MO
Licensed Practical Nurse 037659
From May 24, 2017 through the filing of the Complaint on June 30, 2017, Respondent failed to check in with NTS on second nurse sign off on the disposal as required. Licensee was the last person in possession of the medication and she failed to properly document what happened to the medication. It was discovered that on June 3, 2014, Licensee had charted that 18.75 ml of Roxanol for patient DD had been disposed of; however, Licensee did not have a second nurse sign off on the disposal as required. Probation 11/24/2017 to 11/24/2018

Evans, Colleen Marie
Desloge, MO
Registered Nurse 2011023484
The Administrator discovered that there were missing medication count sheets, missing medications, and a failure to follow the proper practices and systems by Licensee. On July 29, 2014, Licensee was requested to submit a sample for drug and alcohol screening. Licensee initially agreed to provide the sample, but declined to provide a sample when at the collection site. It was discovered that Licensee had charted that 22.00 ml of Roxanol for patient DD had been disposed of; however, Licensee did not have a second nurse sign off on the disposal as required. Probation 09/07/2017 to 09/07/2022

Cuestas, Theresa Marie
Bowling Green, MO
Licensed Practical Nurse 2010029473
On April 27, 2016, correctional facility custody staff received an anonymous note alleging that Licensee was embezzling medications. On May 31, 2016, Licensee was asked to submit to a drug screen sample which showed positive for oxycodone and oxymorphone, and the sample was positive for benzodiazepine, oxycodone, and oxymorphone. Licensee admitted she had taken her father’s prescription of Percocet which is a name brand of oxycodone. Licensee did not have a prescription for, or a lawful reason to possess, oxycodone or oxymorphone. Probation 11/24/2017 to 11/24/2020

Grant, Cynica G
Belleville, IL
Registered Nurse 2011003658
On March 7, 2013, Respondent pled guilty to the offense of Embezzlement of Public Funds due to Respondent knowingly receiving excessive unemployment monies. Probation 09/07/2017 to 09/07/2018

CUESTAS, Theresa Marie
Bowling Green, MO
Licensed Practical Nurse 2010029473
On April 27, 2016, correctional facility custody staff received an anonymous note alleging that Licensee was embezzling medications. On May 31, 2016, Licensee was asked to submit to a drug screen sample which showed positive for oxycodone and oxymorphone, and the sample was positive for benzodiazepine, oxycodone, and oxymorphone. Licensee admitted she had taken her father’s prescription of Percocet which is a name brand of oxycodone. Licensee did not have a prescription for, or a lawful reason to possess, oxycodone or oxymorphone. Probation 11/24/2017 to 11/24/2020

Franklin, Mary Frances
Kidder, MO
Licensed Practical Nurse 2017034764
On May 7, 2013, Applicant pled guilty to the class A misdemeanor of passing a bad check. Applicant’s plea of guilty to passing a bad check, under these circumstances, is an offense for which fraud and dishonesty are essential elements and is an offense involving moral turpitude giving cause to deny Applicant’s application for licensure. Probation 09/26/2017 to 09/26/2022

Mindingall, Ubah A
Independence, MO
Registered Nurse 2005030330
The Missouri State Board of Nursing received information from the Arizona Board of Nursing that Respondent was denied initial licensure in the State of Arizona in an Order of Denial (Order) dated March 23, 2017. In the Order, Respondent was also ordered to cease and desist the practice of nursing in Arizona using her Nurse Licensure Compact privilege to practice. Probation 09/12/2017 to 09/22/2018

Nurmela, Sherry M
Valley Park, MO
Registered Nurse 148373
Licensee worked as a nurse in Missouri without a license from May 1, 2017 until July 13, 2017. This is the second time that Licensee has worked without a license having done so previously from May 1, 2011 through June 10, 2011 without a license. Probation 10/05/2017 to 10/26/2017

Irwin, Tracy L
Alffon, MO
Registered Nurse 2007011285
As part of the renewal process, Licensee was required to complete a chemical dependency packet. In the packet, Licensee reports that she was terminated from her employer in 2012 for suspicion of drug use and diversion. She also reports that in March 2015, she was terminated from another place of employment due to diverting medications. On July 8, 2015, Licensee pled guilty to the offense of petty larceny in the Municipal Court of Creve Coeur, Missouri. Licensee received a suspended imposition of sentence with two years of probation. Licensee reports that this charge was related to her diverting medication from her employer. Licensee reports that she voluntarily admitted herself to The Watershed Addiction Treatment Program on three separate occasions: September 29, 2014 until October 1, 2014; October 3, 2014 until October 20, 2014; and October 21, 2014 until December 1, 2014. Licensee was diagnosed with opiate dependence and sedative dependence. She successfully completed the prescribed treatment interventions. Licensee reported that she used abused heroin, Dilaudid, Vicodin, and temazepam. Licensee states that her sobriety date is June 23, 2015, and she attends Narcotics Anonymous meetings twice weekly. She has a sponsor for the past two years. Licensee received a substance abuse evaluation on June 27, 2017, which recommended continued bi-weekly narcotics anonymous meeting attendance, daily communication with her sponsor, and drug testing. Probation 11/28/2017 to 11/28/2021

Mccrea, Ida J
Doniphan, MO
Registered Nurse 086500
During the period from April, 2013, through July, 2013, licensee wrote out prescriptions for Tramadol for her son who has traumatic injuries. These prescriptions were picked up by him. Some or all of these prescriptions were picked up at the pharmacy by licensee. Licensee on at least one occasion signed her name upon pick up as “Ida Snook,” a name she has been known by in the area. Officials were notified and began an investigation and noted that the son’s medical chart did not show the prescriptions. Licensee was requested to submit a drug screen sample and the sample tested positive for barbiturates, but licensee had a valid prescription for Fioricet at that time and Fioricet contains no drug of abuse. Probation 11/24/2017 to 11/24/2020

Winkelmann, Tonya D
Ellisville, MO
Registered Nurse 2007000552
On March 8, 2017, Respondent pled guilty to the class A misdemeanor of identity theft. Thereafter, in violation of 65.070.223 RSMo, in the Circuit Court of Cole County, Missouri, in case number 15AC-CR02792. Probation 09/07/2017 to 09/07/2018

Radford, Lynnette Kay
Lampe, MO
Registered Nurse 2017041613
On or about August 28, 2015, the Kansas Board of Nursing issued its Proposed Default Order revoking Licensee’s Kansas nursing license, effective September 8, 2015. In the original Petition, the Kansas Board found that Licensee had been repeatedly negligent in the care of patients and had failed to follow policies and procedures designed to safeguard the patients, which is cause for discipline in this State. Licensee has been placed under specified terms and conditions. On March 31, 2017, the Kansas Board of Nursing issued its Consent Agreement and Final Order reinstating Licensee’s Kansas nursing license with specific stipulations. Probation 11/28/2017 to 11/28/2019

Dewin, Rebecca A
Fioravanti, MO
Registered Nurse 145452
On or about August 28, 2015, the Kansas Board of Nursing issued its Proposed Default Order revoking Licensee’s Kansas nursing license, effective September 8, 2015. In the original Petition, the Kansas Board found that Licensee had been repeatedly negligent in the care of patients and had failed to follow policies and procedures designed to safeguard the patients, which is cause for discipline in this State. Licensee has been placed under specified terms and conditions. On March 31, 2017, the Kansas Board of Nursing issued its Consent Agreement and Final Order reinstating Licensee’s Kansas nursing license with specific stipulations. Probation 11/28/2017 to 11/28/2019

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hospital administrators requested that Licensee submit a urine sample for a cause drug test. The sample Licensee submitted tested positive for fentanyl. Probation 09/12/2017 to 09/12/2020

Koch, Amie Marie Chaffee, MO Licensed Practical Nurse 2010034034 On May 11, 2017, Respondent pled guilty to the class C felony of Possession of a Controlled Substance Except 35 Grams or less of Marijuana. Probation 09/07/2017 to 09/07/2022

Myers, Natasha Rae Hannibal, MO Licensed Practical Nurse 2008425272 On November 1, 2011, Licensee pled guilty to the class B misdemeanor of driving while intoxicated. On November 6, 2013, Licensee pled guilty to the class B misdemeanor of driving while intoxicated. Licensee has completed alcohol treatment three times since 2010. On November 13, 2014, Licensee pled guilty to the class A misdemeanor of driving while intoxicated. Licensee stated to the Board that she does not attend support group meetings, does not have a sponsor, and does not have a sobriety date. Effective December 11, 2013, a fine of $650, one year of probation and three years of adult parole follows. Probation 11/24/2017 to 11/24/2022

Manar, Patricia Starr Smithville, MO Licensed Practical Nurse 2014030164 On June 15, 2016, a patient’s mother contacted the agency regarding a medication being left at the patient’s room leaving her home before the end of the scheduled shift. Further, the patient’s mother informed agency officials that Licensee had left early on June 14, 2016, and had not worked her assigned shift on June 8, 2016. Licensee had submitted timesheets signed by the patient’s mother for all three dates and alleging that Licensee had completed the full scheduled shifts. The patient’s mother stated that she did not sign the time sheets of the dates and times indicated on June 8, 2016, June 14 and 15, 2016. Licensee submitted a timesheet and progress note indicating that she had been caring for the patient on June 8, 2016, from 0700 until 1700. Licensee documented that she had administered medications at 0800, 1000, and 1500. Licensee performed a patient assessment at 0800, performed a patient feeding at 1100, and that the patient went to camp at 0930. Licensee later admitted to the Board’s investigator that she had written the progress notes the previous day and stated she had not gotten to the patients home until 12:00 p.m. Probation 11/21/2017 to 11/21/2018

Sanal, Laura M Kansas City, MO Registered Nurse 146422 In January 2013 an audit was performed on Licensee’s narcotic usage at the hospital, and multiple discrepancies were noted. When questioned by hospital administration about the discrepancies, Licensee admitted that she had diverted oxycodone on several different occasions. Licensee was employed as a registered professional nurse at another hospital. On January 14, 2016, Licensee was witnessed by a coworker removing a bag of medication from the pharmacy technician’s drug restocking cart. The medication bag contained controlled substances under 0959.O7 RSMo., including Methadone pills, hydrocodone pills, oxycodone pills, oxycodone injection cartridges, fentanyl syringes, lorazepam pills, and morphine syringes. Licensee admitted to her supervisor that she had diverted the medication from the pharmacy technician’s cart. Licensee took possession of controlled substance medications which she had no valid reason to possess. An audit of the pharmacy administration was also run. On five (5) occasions, Licensee withdrew controlled substance medications and failed to properly document the administration, waste, or return of the controlled substance medications. Probation 11/21/2017 to 11/21/2021

Disciplinary Actions**

Winn, Jeffery Allen Saint Louis, MO Registered Nurse On January 14, 2016, Respondent pled guilty to three counts of the offense of False Statements Relating to Health Care Matters. Probation 09/11/2017 to 09/11/2018

Little, Mykhaele Aleasean Columbia, MO Licensed Practical Nurse 2007030896 On February 11, 2017, after Licensee had provided care for patient H.F., patient H.F. was admitted to the Emergency room for being unresponsive and having bradycardia. It was discovered that on both days, Licensee had removed an unmarked syringe of Clonidine from the refrigerator at the patient’s home and administered it to the patient. Licensee stated she thought that the unmarked syringe contained the patient’s pro-biotic. Licensee admitted that she administered the contents of an unmarked syringe to patient H.F. on two (2) occasions. Probation 09/20/2017 to 09/20/2018

Stewart, Melissa Kathleen Osceola, MO Licensed Practical Nurse 2011000748 In October 2012, DGN reviewed pharmacy delivery/ check-in sheets and discovered that the nursing home had received tramadol, a pain medication, for a resident who did not have a physician’s order to receive it. After DGN reviewed the pharmacy and medical records, she determined that Respondent had ordered tramadol from the pharmacy for three residents who did not have a physician’s order for tramadol. Respondent ordered approximately 900 pills of tramadol in total for the three nursing home residents during the four-month period. Respondent admitted that she ordered the tramadol for the three residents without a physician’s order and removed the medication from the facility. Probation 09/05/2017 to 09/05/2022

Muenks, Scott Francis Jefferson City, MO Registered Nurse 2004802788 On or about May 5, 2017, the Board received a complaint against the nursing license of Applicant from Fulton Medical Center (Fulton). Fulton reported that Applicant was terminated from the nursing position at Fulton. On April 27, 2017, Fulton administrators became aware that three (3) vials of Demerol were missing from the Demerol Pyxis drawer on January 1, 2017 and then cancelled the transaction. Applicant additionally accessed the lab to perform a for cause drug test. The sample which showed a low creatinine reading. A creatinine reading below 20.0 is suspicious for a diluted sample. Probation 05/09/2017

Marsh, Melissa Dawn West Plains, MO Registered Nurse 2012017773 On July 12, 2017, Respondent failed to check in with NTS on one (1) day. Further, on April 25, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on six (6) separate occasions, February 20, 2017; April 10, 2017; May 8, 2017; May 19, 2017; May 30, 2017; and June 16, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 20.0 is suspicious for a diluted sample. Probation 05/09/2017

Smith, Keanan Sean Belleville, IL Licensed Practical Nurse 2004034001 The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 8, 2017. Probation 05/09/2017

REMOVED continued on page 16

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Missouri State Board of Nursing
February, March, April 2018

REVOKED continued from page 15

Dorsey, Meghan Rose
Nerfolk, VA
Licensed Practical Nurse 2018005424
On November 8, 2016, Respondent pled guilty to the class D felony of Fraudulently Attempting to Obtain a Controlled Substance by Fraud or Deceit. Revoked 10/05/2017 to

Shank, Lisa K
Arnold, MO
Licensed Practical Nurse 049477
COUNT I: On November 9, 2014, Respondent provided care for patient AE. After Respondent’s shift on November 9, 2014 it was reported that Respondent could barely stand and had to hold onto the wall to keep from falling. Respondent appeared to be falling asleep while standing and talking; had red, watery eyes and made frequent trips to the bathroom; did not give patient AE all of her scheduled medications or her bolus; and, Respondent failed to document all care provided and Respondent’s nursing notes were not legible. On November 12, 2014, Respondent did not complete a patient assessment for patient EB. Respondent, in her narrative regarding patient EB’s care, stated that the patient is able to communicate simple answers. However, patient EB is nonverbal and unable to give simple answers. Respondent also noted that they attended a holiday party; however, there was no holiday party during her shift with the patient. The Nurse Manager of the agency stated that during a meeting with Respondent on November 17, 2014, Respondent showed signs of impairment such as having trouble pulling her chair out to sit down, failing to make eye contact, breathing heavily, leaning on the table during the meeting, holding her head up with her hands, consistently moving very slowly, disoriented in answering questions, and stumbling and almost walking into a desk. After the meeting, Respondent was observed drinking a bottle of alcohol in her car. COUNT II: On June 20, 2015, the nursing home DON was notified that a card of hydrocodone pills and the sign out sheet for the card were missing. On July 1, 2015, Respondent was interviewed hydrocodone pills and the sign out sheet for the card were missing. On July 1, 2015, Respondent was interviewed by the police department and confessed to taking the hydrocodone pills. On June 23, 2016, Respondent was added to the State of Missouri Department of Health and Senior Services’ employee disqualification list for a period of ten years. Revoked 11/28/2017

Clark, Raeanne Kay
Springfield, MO
Licensed Practical Nurse 2001026766
On August 5, 2016, Respondent arrived at work to begin her 2:00 PM to 10:00 PM shift. Respondent began to take report on the patients she was assigned to care for during her shift. Respondent’s coworkers observed Respondent to be in an intoxicated condition as she started her shift. Respondent smelled of alcohol, had slurred speech, her eyes were glassy, and she was unable to comprehend the reports she was receiving on her patients. Respondent was also unable to use a key to unlock and open the medication cart. Respondent was asked to submit a sample for a reasonable suspicion drug screening. Respondent refused the drug screen and proceeded to attempt to leave the facility. Respondent was subsequently arrested in the parking lot of the nursing home by the Police Department for driving while intoxicated. A Police Officer searched Respondent’s car at the arrest and discovered several open beer cans in the car. On January 19, 2017, Respondent pled guilty to Driving While Intoxicated. Respondent checked into a hospital on August 9, 2016 for treatment of alcohol withdrawal. Respondent was employed by a hospital from September 13, 2004 through March 22, 2016. Respondent’s employment with the hospital was terminated on March 22, 2016. Respondent left her work area without reporting to an oncoming nurse, and was found in her car drinking an alcoholic beverage. Revoked 11/28/2017

League, Heidi Lynn
Lees Summit, MO
Licensed Practical Nurse 2008027500
From July 31, 2017 until the filing of the Complaint on September 21, 2017, Respondent failed to check in with NTS on nineteen days. Further, on August 18, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on August 29, 2017 and September 13, 2017, Respondent failed to check in with NTS; however, these were days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on August 29, 2017 and September 13, 2017. Pursuant to the terms of the Order, Respondent was required to submit a chemical dependency evaluation to the Board within eight weeks of the effective date of the Order, with a due date of August 21, 2017. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent’s behalf. In accordance with the terms of the Order, Respondent was required to undergo a thorough evaluation performed by a licensed mental health professional and have the results submitted to the Board within eight weeks of the effective date of the Order, with a due date of August 21, 2017. The Board did not receive a thorough mental health evaluation submitted on Respondent’s behalf. Revoked 11/28/2017

Lenhardt, Lisa Ann
De Soto, MO
Licensed Practical Nurse 2001026626
The Board did not receive an employer evaluation or statement of unfitness from the donor hospital from September 13, 2004 through March 22, 2016. In accordance with the terms of the Agreement, Respondent was required to undergo a thorough mental health evaluation submitted on Respondent’s behalf. In accordance with the terms of the Agreement, Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by May 30, 2017. As of the filing of the Complaint, the Board had not received proof of any completed hours. Revoked 11/28/2017 to

Hornback, Tena M
Sarcoxie, MO
Registered Nurse 120822
From April 6, 2017 through September 22, 2017, Respondent failed to check in with NTS on eight days. On September 14, 2017, Respondent failed to check in with NTS; however, it was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on September 14, 2017. In addition, on four separate occasions, April 21, 2017; August 2, 2017; August 8, 2017; and September 7, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 2.0 is suspicious for a diluted sample. On September 7, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of methamphetamine. Respondent unlawfully possessed amphetamine. Revoked 11/28/2017

Shy, Janet Rebekah
Desloge, MO
Licensed Practical Nurse 037659
On July 20, 2017 and August 15, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on the two days. On August 2, 2017; August 2, 2017; and August 7, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 2.0 is suspicious for a diluted sample. On August 7, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of methamphetamine. Revoked 11/28/2017

...
Reynolds, Kimberly S
Saint Joseph, MO
Registered Nurse 156020
On February 11, 2015, co-workers reported that Respondent was speaking loudly and rudely to a coworker at the home while in the presence of nursing home patients. The home administrators received further reports regarding Respondent’s rude interactions with coworkers and medication administration concerns. On September 2, 2015, Respondent was sent home at around 12:30 while the nursing home began an investigation into Respondent’s conduct. After Respondent had left, the nurse who took over care for Respondent’s patients discovered that there was an error for one of the patient’s narcotic medication inventory. On September 2, 2015, Respondent documented the withdrawal of one Norco 7.5-325 pill for patent BB at 16:00. Respondent failed to document the administration, waste or return of the pill. Additionally, Respondent had been sent home at 12:30 and could not have withdrawn the medication at 16:00. Nursing home administrators then reviewed Respondent’s narcotic medication withdrawals and administrations and several other errors were discovered. On August 31, 2015, Respondent withdrew one Norco 7.5-325 pill for patient CW at 07:30, 11:30, and 16:00 for a total of three pills. Respondent documented the administration of one Norco 7.5-325 pill at 10:40. Respondent failed to document the administration, waste, or return of the remaining two Norco pills. On September 2, 2015, Respondent documented the withdrawal of one Norco 5-325 pill for patient BB at 09:00. Respondent failed to document the administration waste or return of the pill. On September 2, 2015, Respondent documented the withdrawal of one Norco 5-325 pill for patient BB at 09:00. Respondent failed to document the administration waste or return of the pill. Additionally, patient JS had orders for the Norco medication every six hours. The previous administration was at 07:00 on August 31, 2015. Respondent was sent home at 12:30, so Respondent’s withdrawal was in violation of the orders for the patient. On August 31, 2015, Respondent withdrew two Norco 7.5-325 pills for patient LH. Only one pill was documented as administered to patient LH. Respondent failed to document the administration, waste or return of the second pill. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case. 
Revolved 11/28/2017

Hein, Denise J
Webster Groves, MO
Registered Nurse 074537
On December 5, 2016, Respondent was found guilty of the class A felony of Murder in the Second Degree. 
Revolved 09/05/2017

Farris, Elizabeth Ann
Benton, AR
Registered Nurse 2006043104
On May 11, 2016, three narcotic medications were removed from the narcotic administration system at the home at around 12:30 while the nursing home began an investigation into Respondent’s conduct. After Respondent had left, the nurse who took over care for Respondent’s patients discovered that there was an error for one of the patient’s narcotic medication inventory. On September 2, 2015, Respondent documented the withdrawal of one Norco 7.5-325 pill for patient BB at 16:00. Respondent failed to document the administration, waste or return of the pill. Additionally, Respondent had been sent home at 12:30 and could not have withdrawn the medication at 16:00. Nursing home administrators then reviewed Respondent’s narcotic medication withdrawals and administrations and several other errors were discovered. On August 31, 2015, Respondent withdrew one Norco 7.5-325 pill for patient CW at 07:30, 11:30, and 16:00 for a total of three pills. Respondent documented the administration of one Norco 7.5-325 pill at 10:40. Respondent failed to document the administration waste or return of the pill. On September 2, 2015, Respondent documented the withdrawal of one Norco 5-325 pill for patient BB at 09:00. Respondent failed to document the administration waste or return of the pill. Additionally, patient JS had orders for the Norco medication every six hours. The previous administration was at 07:00 on August 31, 2015. Respondent was sent home at 12:30, so Respondent’s withdrawal was in violation of the orders for the patient. On August 31, 2015, Respondent withdrew two Norco 7.5-325 pills for patient LH. Only one pill was documented as administered to patient LH. Respondent failed to document the administration, waste or return of the second pill. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case. 
Revolved 11/28/2017

Patten, Mary Jo
Warwick, MO
Registered Nurse 2016043208
Respondent never completed the contract process with NTS. The Board did not receive an employer evaluation or statement of unemployment by the quarterly due dates of March 9, 2017 or June 9, 2017. Respondent did not attend the meeting or contact the Board to reschedule the meeting. She did call the Board and state that she could not attend; however, a subsequent return phone call by the Director of Compliance to her was not returned by Respondent. Respondent has no intention of complying with the probatory terms. 
Revolved 09/07/2017

Carter, Mary C
Arnold, MO
Registered Nurse 2013024798
On June 9, 2015 the Director of Pharmacy at the Hospital discovered a large number of suspect transactions in the medication dispensing system (Pyxis). The Director of Pharmacy specifically discovered 2 vials removed that appeared to have been tampered with as well. The vials withdrawn from the Pyxis system had liquid but the seals were broken. Upon investigation, the Hospital staff discovered Respondent accessed hydromorphone on June 9, 2015, but did not administer the drug to any patient. Respondent acquired the Hydromorphone on June 9, 2015, from a floor of the hospital that was closed, with no patients, where she was not working. Respondent admitted to diverting the Hydromorphone. Respondent admitted to ingesting the Hydromorphone. Respondent admitted the vials that were tampered with actually contained saline. The Director further found Respondent had diverted medication on other occasions. Respondent diverted hydromorphone in January 2015. Respondent diverted medication on other occasions. Respondent acquired the Hydromorphone in the medication room at 6:00 a.m. when her shift did not begin until 7:00 a.m. Respondent was witnessed on several occasions wasting Hydromorphone with a witness, but in retrospect the witness did not confirm positive for Oxymorphone. Respondent did not document the administration, waste or return of the pill. On September 2, 2015, Respondent was sent home at 12:30 while the nursing home began an investigation into Respondent’s conduct. After Respondent had left, the nurse who took over care for Respondent’s patients discovered that there was an error for one of the patient’s narcotic medication inventory. On September 2, 2015, Respondent documented the withdrawal of one Norco 7.5-325 pill for patient BB at 16:00. Respondent failed to document the administration, waste or return of the pill. Additionally, Respondent had been sent home at 12:30 and could not have withdrawn the medication at 16:00. Nursing home administrators then reviewed Respondent’s narcotic medication withdrawals and administrations and several other errors were discovered. On August 31, 2015, Respondent withdrew one Norco 7.5-325 pill for patient CW at 07:30, 11:30, and 16:00 for a total of three pills. Respondent documented the administration of one Norco 7.5-325 pill at 10:40. Respondent failed to document the administration waste or return of the pill. On September 2, 2015, Respondent documented the withdrawal of one Norco 5-325 pill for patient BB at 09:00. Respondent failed to document the administration waste or return of the pill. Additionally, patient JS had orders for the Norco medication every six hours. The previous administration was at 07:00 on August 31, 2015. Respondent was sent home at 12:30, so Respondent’s withdrawal was in violation of the orders for the patient. On August 31, 2015, Respondent withdrew two Norco 7.5-325 pills for patient LH. Only one pill was documented as administered to patient LH. Respondent failed to document the administration, waste or return of the second pill. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case. 
Revolved 11/28/2017

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Disciplinary Actions**

Revolved continued on page 18
Missouri State Board of Nursing February, March, April 2018

Respondent refused, and immediately left the facility and never returned.
Revolved 11/28/2017

Singleton, Ellen C
Artważe, Joseph
Licensed Practical Nurse 056035
On November 12, 2015, Respondent reported to a patient’s home to work. After only being at the patient’s home for approximately ten minutes, she left. On November 12, 2015, Respondent was called into a meeting with her supervisor to discuss her leaving the clients home after only ten minutes of being there. During the above mentioned meeting, Respondent was witnessed fidgeting, bouncing a lot, and would not make eye contact. On November 12, 2015, Respondent was asked to submit to a for-cause drug screen. On or about November 20, 2015, Respondent’s sample returned positive for marijuana, methamphetamine, and amphetamine. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case.
Revolved 11/28/2017

Hammond, Lisa Renea
Sikeston, MO
Registered Nurse 2013025426
On or about July 13, 2015, charge nurse A.F removed six (6) prn hydrocodone pills from Alixa using her user name and password. Respondent had removed six (6) prn hydrocodone pills to the patients in the computer system. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case.
Revolved 11/28/2017

James, Deborah K
Springfield, MO
Registered Nurse 101789
The Missouri State Board of Nursing received information from the California Board of Nursing via the NURSYS website that Respondent’s Privilege to Practice in the state of Missouri was revoked in a Default Decision and Order dated May 13, 2016. The Missouri State Board of Nursing received information from the Texas Board of Nursing via the NURSYS website that Respondent’s license to Practice nursing in the state of Texas was revoked in a Default Decision and Order dated November 8, 2016.
Revolved 09/22/2017

SUSPENDED

Gomez, JaCey Beth
Savannah, MO
Licensed Practical Nurse 2009029700
Suspended 11/21/17 to 12/30/17; Probated 12/06/16 to 12/06/19
On December 1, 2016, Licensee was informed by a certified nurse’s assistant that Resident GS refused to shower. Licensee told the CNA to make the resident bathe. In route to the shower resident GS questioned who was making her shower. Licensee raised her voice
e-mailed letter from Dr. T. dated June 7, 2017, stating that he was not made aware of the previous amounts or prescriptions that had been previously prescribed, but was aware of an “alarm of a chemical dependency.” Respondent failed to disclose the previous prescriptions to Dr. L. P., Dr. T. and L. M. before obtaining the new prescriptions on April 6, April 19, and May 8, 2017, within 60 days prior to receiving the prescriptions.
Revolved 09/07/2017

Walter, Kenya Monique
Grandview, MO
Registered Nurse 2006025384
Respondent failed to check in with NTS on twenty-three (23) days. In addition, on October 28, 2015, Respondent failed to call NTS; however, that was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on October 28, 2015. Further, on March 25, 2016, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on two separate occasions, March 17, 2016, and April 28, 2016, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On June 23, 2016, Respondent submitted urine and nail samples for random drug screening. That urine sample tested positive for the presence of Lorcazepam. The nail sample tested positive for the presence of Oxycodone. Respondent did not have a prescription for, or a lawful reason to possess, Lorcazepam or Oxycodone. On February 23, 2017, Respondent submitted a urine sample for random drug screening. That urine sample tested positive for the presence of marijuana. Respondent does not have a prescription for, or a lawful reason to possess, marijuana. On May 8, 2017, Respondent submitted a urine sample for random drug screening. That urine sample tested positive for the presence of oxymorphone.
Revolved 09/22/2017

McCarty, Connie Marie
Rockaway Beach, MO
Registered Nurse 2008020781
Respondent failed to check in with NTS on six (6) days. In addition, on five (5) separate occasions, May 26, 2015; February 11, 2016; June 10, 2016; November 21, 2016; and June 12, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On March 28, 2017, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. On June 29, 2017, Respondent reported to a collection site to provide a blood sample, and the sample tested positive for Phosphatidyl Ethanol (PEth), a metabolite of alcohol. Respondent admitted to Dr. Greg Elam that she had been drinking on weekends and would typically have four (4) drinks.
Revolved 09/07/2017

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Disciplinary Actions**

Revolved continued from page 17

Respondent refused, and immediately left the facility and never returned.
Revolved 11/28/2017

Lines, Julie Michelle
Butler, MO
Licensed Practical Nurse 2007024012
On four (4) separate occasions, September 23, 2016; October 11, 2017; October 19, 2017; and, March 31, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On March 31, 2017, the Board received a prescription identification form from Dr. J. P. for 60 tablets of Oxycontin 60mg and 120 tablets of oxycodone 30 mg on March 24, 2017, for pain. On May 26, 2017, the Board received a prescription identification form from Dr. L. P., prescribing Respondent 60 tablets of Oxycontin 60 mg and 120 tablets of oxycodone 30 mg on April 6, 2017, for low back pain. On May 26, 2017, the Board received a prescription identification form from Dr. C. T., prescribing Respondent ten (10) pills of Norco on April 19, 2017, for pain from a root canal. On May 30, 2017, the Board received a prescription identification form from Dr. L. P., prescribing Respondent 60 tablets of Oxycontin 60 mg and 120 tablets of oxycodone 30 mg on May 8, 2017, for back pain. On May 30, 2017, the Board received a prescription identification form from Dr. L. P., prescribing Respondent 60 tablets of Oxycodin 60 mg and 120 tablets of oxycodone 30 mg on May 8, 2017, for back pain.
Revolved 11/28/2017

SUSPENDED

Gomez, JaCey Beth
Savannah, MO
Licensed Practical Nurse 2009029700
Suspended 11/21/17 to 12/30/17; Probated 12/06/16 to 12/06/19
On December 1, 2016, Licensee was informed by a certified nurse’s assistant that Resident GS refused to shower. Licensee told the CNA to make the resident bathe. In route to the shower resident GS questioned who was making her shower. Licensee raised her voice

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to resident GS to state that it was her that was making the resident shower. Licensee got into a verbal altercation with resident GS. Further, on December 1, 2016, resident SV spoke with the Administrator of the nursing home regarding Licensee. Resident SV informed the Administrator that Respondent told him that he could not bother the doctors that day or she would take away his electric wheelchair. Additionally, on December 1, 2016, Licensee made resident CM get up and go to breakfast even though resident CM did not want to. Resident CM had informed Licensee that she had been up late and did not want to go to breakfast.

Suspension 11/21/2017 to 12/05/2017

VOLUNTARY SURRENDER

Colvin, Raylene Fay
Kansas City, MO
Registered Nurse 2002028990
Licensee voluntarily surrendered her Missouri nursing license effective November 8, 2017.
Voluntary Surrender 11/08/2017

Smith, Stacia Lee
Nevada, MO
Registered Nurse 2006002040
Licensee was expected to visit patient RH’s home on a weekly basis to set up medications. On August 23, 2016, agency administrators received information indicating that Licensee had not visited patient RH’s home since June. Licensee had submitted Nurse Visit Reports and timesheets for visits on July 4, 2016; July 11, 2016; July 18, 2016; July 25, 2016; August 1, 2016; August 8, 2016; and August 15, 2016. When questioned by agency administrators, patient RH confirmed that Licensee had not visited the home since June 2016, and stated that the signatures on Licensee’s Nurse Visit Reports were not his. On July 11, 2017, Licensee pled guilty to six (6) counts of the class A misdemeanor of Theft/Stealing. Licensee pled guilty to appropriating health care payments.
Voluntary Surrender 10/16/2017

Hogard, Michael E
Lee's Summit, MO
Registered Nurse 135356
Licensee had submitted Nurse Visit Reports and timesheets for visits on July 4, 2016; July 11, 2016; July 18, 2016; July 25, 2016; August 1, 2016; August 8, 2016; and August 15, 2016. When questioned by agency administrators, patient RH confirmed that Licensee had not visited the home since June 2016, and stated that the signatures on Licensee’s Nurse Visit Reports were not his. On July 11, 2017, Licensee pled guilty to six (6) counts of the class A misdemeanor of Theft/Stealing. Licensee pled guilty to appropriating health care payments.
Voluntary Surrender 10/16/2017

Owens, Courtney Diane
Burlington Junction, MO
Registered Nurse 2004011095
Licensee voluntarily surrendered her Missouri nursing license effective November 8, 2017.
Voluntary Surrender 11/08/2017

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