

BEFORE THE TEXAS BOARD OF NURSING



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

In the Matter of Vocational Nurse
License Number 185272
issued to SHERENA ANN LEATHERMAN

§ AGREED
§
§ ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Bo considered the matter of SHERENA ANN LEATHERMAN, Vocational Nurse License Nun 185272, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on January 9, 2011, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice vocational nursing in the State of Texas.
4. Respondent received a Certificate in Vocational Nursing from Amarillo College, Amarillo, Texas, on May 24, 2002. Respondent was licensed to practice vocational nursing in the State of Texas on August 8, 2002.
5. Respondent's nursing employment history includes:

08/2002 - 02/2003

Staff Nurse

Ware Memorial Care Center
Amarillo, Texas

Respondent's nursing employment history continued:

03/2003 - 05/2003	Staff Nurse	Biomat USA Plasma Center Amarillo, Texas
06/2003 - 05/2004		Unknown
06/2004 - 09/2004	Staff Nurse	Craig Methodist Retirement Community Amarillo, Texas
10/2004 - 04/2005		Unknown
05/2005 - 08/2005	Staff Nurse	Laurel Ridge Clovis, New Mexico
09/2005 - 08/2006		Unknown
09/2006 - 11/2006	Staff Nurse	Pampa Nursing Center Pampa, Texas
12/2006 - 02/2007		Unknown
03/2007 - 05/2007	Staff Nurse	Baptist St. Anthony's Hospital Amarillo, Texas
06/2007 - 08/2008	Staff Nurse	St. Anthony's Healthcare and Rehabilitation Center
09/2008 - 11/2008		Unknown
12/2008 - 08/2009	Staff Nurse	Interim Healthcare Clovis, New Mexico
09/2009 - 04/2010	Staff Nurse	Canyon Healthcare Canyon, Texas
Unknown	Staff Nurse	Triumph Hospital Amarillo, Texas

6. At the time of the initial incident, Respondent was employed as a LVN Staff Nurse with St. Anthony's Healthcare and Rehabilitation Center, Clovis, New Mexico, and had been in this position for two (2) months.

7. On or about August 12, 2008, while utilizing Respondent's multistate licensure compact privilege associated with her license to practice as a licensed vocational nursing in the State of Texas, and while employed with St. Anthony's Healthcare and Rehab, Clovis, New Mexico, Respondent failed to administer Lasix (diuretic / blood pressure medication) to Residents M.F. and W.E; Labetalol (blood pressure medication) to Resident J.R.; Fexofenadine (allergy medication) to Resident E.O.; Paxil (antidepressant medication) and Hydrochlorothiazide (diuretic / blood pressure medication) to Resident V.S.; Vasotec (blood pressure medication) to Resident I.C.; and Cefuroxime (antibiotic medication) to Resident T.M. as ordered by the physician. Respondent then falsified the residents' medical records documenting that the medications were given as ordered. The Director of Nursing took pictures of the "blister packs" holding the ordered medications on August 11, 2008, documenting how many tablets / capsules were in each pack. The Director of Nursing again took pictures of the same blister packs on August 12, 2008, after Respondent had documented administration of the ordered medications to the residents. The number of tablets / capsules were unchanged from the count on August 11, 2008, indicating that Respondent had not administered the medications as ordered and had falsified the medical records by documenting that the medications had been administered to the residents. Respondent's conduct resulted in an inaccurate medical record and was likely to injure the residents in that future care givers would not have accurate information upon which to base their care decisions, and exposed the residents unnecessarily to a risk of harm from non-efficacious treatment and the potential for complications from untreated hypertension, diabetes and infection.
8. On or about August 12, 2008, while utilizing Respondent's multistate licensure compact privilege associated with her license to practice as a licensed vocational nursing in the State of Texas, and while employed with St. Anthony's Healthcare and Rehab, Clovis, New Mexico, Respondent failed to perform finger stick blood glucose checks at 0600 on Resident J.R. and at 0600 and 1100 on Resident S.V., as ordered by the physician. Respondent's conduct was likely to injure the residents in that failure to determine glucose levels prior to the administration of medications could result in non-efficacious treatment.
9. On or about April 6, 2010, while employed with Canyon Healthcare, Canyon, Texas, Respondent failed to appropriately intervene when, at 1045, she obtained a blood glucose reading of "High" which was indicative of a blood glucose level greater than five hundred (500) milligrams /deciliter from Resident Medical Record Number 290101. A normal blood glucose reading in a person with treated diabetes should be under 130 milligrams /deciliter. Respondent notified the Assistant Director of Nursing and the Director of Nursing but did not notify the resident's physician, as required per sliding scale guidelines, and instead waited for delivery of the Resident's medications from the pharmacy to treat the elevated glucose level. Respondent's conduct exposed the resident unnecessarily to a risk of harm in that timely treatment was not provided and the patient later complained of shortness of breath precipitating a transfer to the emergency room for treatment of a dangerously high blood glucose level of more than one thousand (1,000) milligrams /deciliter.

10. In Response to Findings of Fact Seven (7) through nine (9) Respondent states:
- "I believe I gave my medication and performed Accu-checks thus the documentation."
 - "I do admit that I cannot honestly say whether or not I gave the said medication."
 - "I had been under a lot of stress during this week. My children were moving with their Father and an abusive boyfriend was being released, so if I did not give the medication I am sorry."

Regarding the incident on April 6, 2010, while employed with Canyon Healthcare, Canyon, Texas, Respondent states:

- At 0845 she obtained a blood glucose reading of "High", and then documented the reading in the medical record.
- She found that the pharmacy had not yet been delivered the resident's medications.
- She checked the other two medication carts for the ordered insulin but did not find any.
- "I went to my Assistant Director of Nursing and the Director of Nursing and explained what was going on."
- The Assistant Director of Nursing instructed her to call the pharmacy and find out the estimated time of arrival the medication would be at the facility.
- The pharmacy staff told her it would be delivered "shortly".
- The Assistant Director of Nursing was notified who then gave her instructions to notify the oncoming nurse, Wilma, to give insulin when it arrives.
- She gave Wilma full report and told her of the high reading and to administer the insulin when it arrived and to notify the physician.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B),(1)(C),(1)(D), (1)(M)&(2)(A) and 217.12(1)(A),(1)(B),(4)&(6)(A).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 185272, heretofore issued to SHERENA ANN LEATHERMAN, including revocation of Respondent's license to practice nursing in the State of Texas.

ORDER

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

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception;

Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*
<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the

course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

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

(5) RESPONDENT SHALL pay a monetary fine in the amount of five-hundred (\$500.00). RESPONDENT SHALL pay this fine within forty-five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

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

(8) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse or a Licensed Vocational Nurse. Direct supervision requires another professional or vocational nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse or a Licensed Vocational Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the Registered Nurse or Licensed Vocational Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) years of employment as a nurse.

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

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RESPONDENT'S CERTIFICATION

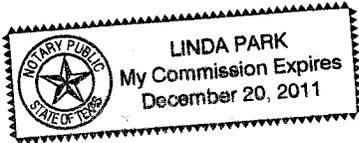
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and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

Signed this 7th day of February, 2011.

Sherena Ann Leatherman
SHERENA ANN LEATHERMAN, Respondent

Sworn to and subscribed before me this 7th day of February, 2011.

SEAL



Linda Park

Notary Public in and for the State of TEXAS

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 7th day of February, 2011, by SHERENA ANN LEATHERMAN, Vocational Nurse License Number 185272, and said Order is final.

Effective this 8th day of March, 2011.



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

