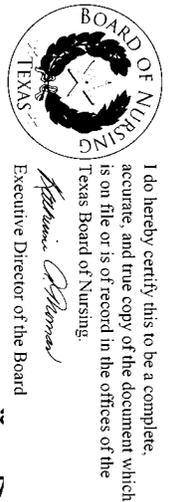


BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Vocational Nurse § AGREED
License Number 162716 §
issued to DEANNA JEANNE LIGON § ORDER



On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of DEANNA JEANNE LIGON, Vocational Nurse License Number 1627 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 22, 2010, by Katherine A. Thomas, MN, RN, Executive Director.

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 Southwest Texas Junior College, Del Rio, Texas, on May 10, 1997. Respondent was licensed to practice vocational nursing in the State of Texas on June 6, 1997.
5. Respondent's vocational nursing employment history includes:

06/97 - 05/98	Unknown	
06/98 - 12/00	ADON	Hill County Healthcare Center Llano, Texas

Respondent's vocational nursing employment history continued:

12/00 - 06/06	LVN	LLano Memorial Healthcare System Llano, Texas
06/06 - 06/07	LVN/Parter	Nightingale Nursing Services Llano, Texas
05/07 - 10/07	Not working in Nursing	
11/07 - 01/08	Unknown	
02/08 - 12/08	LVN	LLano Memorial Healthcare System Llano, Texas
01/09 - Present	Unknown	

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a licensed vocational nurse with LLano Memorial Healthcare System, Llano, Texas, and had been in this position for four (4) months.

7. On or about June 14, 2008, while employed with Llano Memorial Healthcare System, Llano, Texas, Respondent administered Ativan to Patient Medical Record Number 879116 in excess frequency and/or dosage of the physician's order. Respondent administered Ativan 2.5mg; however, the order was written for Ativan 0.25mg. Respondent's conduct was likely to injure the patient in that the administration of Ativan in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states:

"After the physician's assessment was completed, I took a verbal order from the emergency room physician, as he and I were walking past one another. The order I heard was to give the patient Ativan and Norvasc 2.5. I then administered Ativan 2.5mg and Norvasc 2.5mg to the patient. I returned to the nurses' station and looked at the orders the physician had written out for my patient. When I realized that he had written an order for Ativan 0.25mg, I immediately went to the physician and questioned the order. I informed the physician of the medications and doses that I had administered. The physician informed me we would keep the patient in the emergency room for a little while longer just to make sure she was ok. The patient experienced no adverse reactions or side effects to the medications I administered, and she was discharged home with her daughter."

9. On or about June 16, 2008, while employed with Llano Memorial Healthcare System, Llano, Texas, Respondent failed to administer Levaquin 500mg IV to Patient Medical Record Number 879741 at 1700, as ordered by the physician. The patient did not receive his first dose of medication until 0900 the next morning, sixteen (16) hours later. Respondent's conduct delayed the onset of medical treatment and was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.
10. In response to the incident in Finding of Fact Number Nine (9), Respondent states:

"Initial doses of antibiotics are started in the emergency room, unless more than one antibiotic was ordered. In that case, the other antibiotics are not administered until the previous antibiotic has completed infusing. A time is generally assigned by the nurse administering the medication, as it cannot be started until the previous antibiotic has completed infusing...A lot of times, our MARs were not available for us to use...The only way for me to even venture to guess what occurred, is to review the patient documentation, check my time sheet to see if I was still on duty, and review my charting to see if I had indeed admitted the patient to the floor."
11. On or about June 20, 2008, while employed with Llano Memorial Healthcare System, Llano, Texas, Respondent failed to administer Solu-Cortef 40mg to Patient Medical Record Number 880960, as ordered by the physician. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.
12. On or about June 20, 2008, while employed with Llano Memorial Healthcare System, Llano, Texas, Respondent removed Solu-Medrol 40mg from the Omnicell Medication Dispensing System for Patient Medical Record Number 880960, but failed to document its administration in the medication administration record and/or failed to follow the facility's policy and procedure for wastage of the unused portion of the medication. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patient, and was likely to deceive the hospital pharmacy and placed them in violation of Chapter 483 of the Texas Health & Safety Code (Dangerous DrugAct).
13. On or about June 20, 2008, while employed with Llano Memorial Healthcare System, Llano, Texas, Respondent falsely documented that she administered Solu-Cortef 40mg to Patient Medical Record Number 880960 in that she never removed said medication from the Omnicell Medication Dispensing System. Instead, Respondent withdrew Solu-Medrol 40mg. Respondent's conduct resulted in an inaccurate medical record and was likely to injure the patient in that subsequent care givers would not have accurate information to base their decisions for further care.

14. In response to the incidents in Findings of Fact Numbers Eleven (11) to Thirteen (13), Respondent states:

"I am well aware of the difference of solumedrol and solucortef and the fact that the solumedrol has an orange stopper on the vial and solucortef has a light green stopper on the vial. I may have indeed pulled solumedrol out of the omnicell, but I am positive, if you look at the omnicell reports further down, you will find the solucortef was withdrawn by me, although I cannot guarantee that I completed the report to show the return of the solumedrol."

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555 , the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A)(C)&(D) and 217.12(1)(A), (1)(C), (4), (6)(A), (10)(C)&(11)(B).
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 162716, heretofore issued to DEANNA JEANNE LIGON, including revocation of Respondent's license to practice vocational 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 REMEDIAL EDUCATION, 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 multistate licensure privilege, 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 multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to DEANNA JEANNE LIGON to the office of the Texas Board of Nursing within ten (10) days of the date of ratification of this Order.

(2) 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>.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(4) 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>

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

web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.

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

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RESPONDENT'S CERTIFICATION

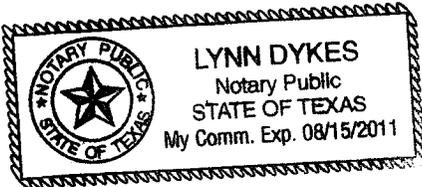
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that when this Order becomes final and the terms of this Order become effective, 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 to practice vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 25 day of 02, 2010.

Deanna Jeanne Ligon
DEANNA JEANNE LIGON, Respondent

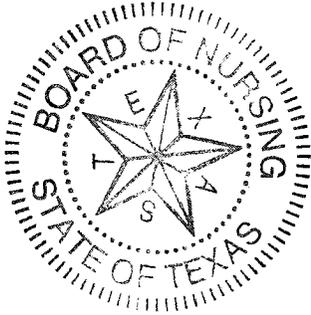
Sworn to and subscribed before me this 25th day of February, 2010.

SEAL



Lynn Dykes
Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 25th day of February, 2010, by DEANNA JEANNE LIGON, Vocational Nurse License Number 162716, and said Order is final.



Effective this 2nd day of March, 2010.


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