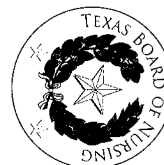

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 547423	§	
issued to GLENDA EARL	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Bo considered the matter of GLENDA EARL, Registered Nurse License Number 547423, hereina 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 informal proceedings, notice and hearing, and agreed to the entry of this Order offered on July 14, 2009, 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 informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Trinity Valley Community College, Kaufman, Texas, on May 1, 1988. Respondent was licensed to practice professional nursing in the State of Texas on September 1, 1988.

5. Respondent's professional nursing employment history includes:

05/88 - 04/90	Staff Nurse PRN	East Texas Medical Center Tyler, Texas
05/88 - 04/92	Nurse Educator	New Medico Corporation Garden Valley, Texas

Respondent's professional nursing employment history continued:

04/92 - 12/97	Case Manager/ Field Nurse	Country Nurses Grand Saline, Texas
12/97 - 01/99	Staff Nurse	Hospice of East Texas Tyler, Texas
01/99 - 10/04	Staff Nurse	Rusk State Hospital Rusk, Texas
10/04 - 06/05	Staff Nurse	Skyview Correctional Center Rusk, Texas
06/05 - 10/05	Staff Nurse	East Texas Medical Center Tyler, Texas
10/05 - 11/05	RN Case Manager	Andrews Center Tyler, Texas
06/06 - 08/06	Staff Nurse	Terrell State Hospital Terrell, Texas
10/06 - Present	Charge Nurse	Rusk State Hospital Rusk, Texas

6. At the time of the incidents, Respondent was employed as Charge Nurse with Rusk State Hospital, Rusk, Texas, and had been in this position for five (5) months.

7. On or about March 25-26, 2007, while employed as Charge Nurse with Rusk State Hospital, Rusk, Texas, Respondent accepted a verbal report that the controlled drug count was correct without counting the medications herself and accepted verbal report that all patients were accounted for without checking the patients. Patient Medical Record Number 306440 had gotten out of the locked unit at the end of the previous shift. Respondent's conduct resulted in inaccurate records and could have resulted in the loss of medication. In addition, Respondent's conduct exposed the patient unnecessarily to a risk of harm in that it resulted in a delayed in identifying that the patient was missing from the unit.

8. On or about March 25-26, 2007, while employed with Rusk State Hospital, Rusk, Texas, Respondent made false entries in the medical record for Patient Medical Record Number 306440, in that Respondent documented in the progress notes at 1:09 am and 1:22 am that the patient was on the unit and sleeping, when in fact the patient had gotten out of the locked unit at the end of the previous shift and was unaccounted for during approximately nine (9) hours during which time he committed several crimes. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the information while providing care to the patient.

9. On or about March 25-26, 2007, while employed as Charge Nurse with Rusk State Hospital, Rusk, Texas, Respondent failed to supervise nursing care provided by staff for whom she was responsible, in that the staff assigned to make rounds failed to identify that Patient Medical Record Number 306440 was not on the unit. The patient had gotten out of a locked unit sometime after 8:00 p.m. and was unaccounted for during approximately nine (9) hours. Respondent's conduct was likely to injure the patient in that failure to supervise staff resulted in a delay in identifying that the patient was not in the facility getting the care that he needed.

10. In response to Findings of Fact Number Seven (7) through Nine (9), Respondent states that on March 25, 2007, she was asked to come in and work her regular units on the 10p-6a shift, due to shortage and she agreed. She was going to work her regular units and she received report at 9:45pm. After report she was told by the charge nurse that she would have to go as a relief nurse to Cypress 8 and work the 10p-6a shift. She walked out of her units and at 10:15pm she was in the hall where she met the regular charge nurse for Cypress 8. The charge nurse told her that she had already been on Cypress 8 and received the unit report including patient count and she reported no problems and stated all patients were on the unit (which was not true as the patient left the unit during 2p - 10p shift). The charge nurse also reported that she had already counted the narcotics with the 2p-10p shift nurse and the count was correct. She handed her the narcotic keys and was prepared to leave. It is understood that the 2-10 shift cannot leave the unit until the patient count is correct and when I arrived on Cypress 8 at approximately 10:30pm to work, the 2p-10p shift was already gone. I received report from a PNA who reported that all the patients were present and accounted for. He had charted this on the Rounds Checksheet at 10:30pm. Respondent states that at approximately 1:00 am she asked a PNA sitting in the hallway where Patient RG's bed was and she instructed her to Room 2 the last bed on the left. Respondent walked into Room 2 and observed the last bed and she charted at 1:09 am. Respondent denies falsifying any charting, but she was told that Patient RG was in the wrong bed and as such she charted on the wrong patient. Respondent states she made a mistake and observed the wrong patient and charted on the wrong patient. Respondent states that as indicated on the Police Report the patient was at the Hardware store at 9:00pm on March 25, 2007, the patient obviously left Rusk on the 2-10 shift shortly after his HS medication that was given at about 8:00pm. Respondent states that she checked the rounds checksheet and the PNA appeared to be making every thirty (30) minute rounds on the patients and completed the required charting. If she had any reason to believe that the PNA was not making rounds properly, she would have done things differently.

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),(B),(D),(P),&(U) and 217.12(1)(F)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 547423, heretofore issued to GLENDA EARL, including revocation of Respondent's license to practice professional 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 WARNING WITH STIPULATIONS, 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 compact states.

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 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 deliver the wallet-sized license issued to GLENDA EARL, to the office of the Texas Board of Nursing within ten (10) days from 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 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://www.learningext.com/products/generalce/critical/ctabout.asp.*

(5) RESPONDENT SHALL pay a monetary fine in the amount of Five Hundred Dollars ($500). 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 ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) 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 duration of the stipulation period, RESPONDENT SHALL be supervised by a Registered 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.

(9) 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 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 one (1) year 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 and RESPONDENT shall be eligible for multistate licensure privileges, if any, to practice nursing in the State of Texas.

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CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. 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 to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

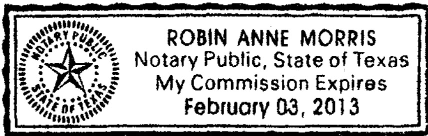
Signed this 11 day of August, 2009.

Glenda Earl

GLENDA EARL, Respondent

Sworn to and subscribed before me this 11th day of August, 2009.

SEAL



Notary Public in and for the State of Texas

Approved as to form and substance.

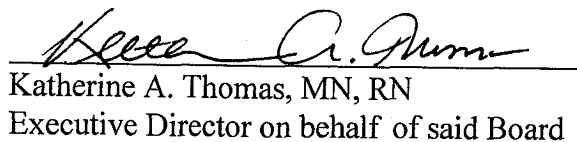
Virginia A. Sloan

Virginia A. Sloan, Attorney for Respondent

Signed this 11 day of August, 2009.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 11th day of August, 2009, by GLENDA EARL, Registered Nurse License Number 547423, and said Order is final.

Effective this **8th** day of **September**, **2009**.



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