IN THE MATTER OF	§	BEFORE THE ELIGIBILITY
	§	
PERMANENT CERTIFICATE	§	AND DISCIPLINARY
	§	
NUMBER 4636703	§	COMMITTEE
	§	
ISSUED TO	§	OF THE TEXAS
	§	
KAREN SUE GLASH	§	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.

Executive Director of the Board

ORDER OF THE BOARD

TO: Karen Sue Glash
2003 Shannon Rd.
Alexandria, LA 71301

During open meeting held in Austin, Texas, on Tuesday, August 18, 2009, the Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case. This case was heard, and based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee of the Texas Board of Nursing finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, chapter 301 of the Texas Occupations Code, for retention of Respondent's license to practice professional nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Eligibility and Disciplinary Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing (22 TEX. ADMIN.CODE § 213.2(j)). All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 463670, previously issued to KAREN SUE GLASH, to practice professional nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 463670, previously issued to KAREN SUE GLASH, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privilege, if any, to practice professional nursing in the State of Texas.

Entered this 18th day of August, 2009.

TEXAS BOARD OF NURSING

BY: _____

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Re: Permanent Certificate Number 463670
Issued to KAREN SUE GLASH
DEFAULT ORDER -REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of August, 2009, a true and correct copy of the foregoing DEFAULT ORDER was served by placement in the U.S. Mail via certified mail, and addressed to the following person(s):

Karen Sue Glash
2003 Shannon Rd.
Alexandria, LA 71301

BY: _____
KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 463670, Issued to	§	
KAREN SUE GLASH, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, KAREN SUE GLASH, is a Registered Nurse holding license number 463670, which is in Delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about June 11, 2008, Respondent's license to practice professional nursing in the State of Louisiana was SUSPENDED by the Louisiana State Board of Nursing, Baton Rouge, Louisiana. A copy of the Findings of Fact, Conclusions of Law and Louisiana State Board of Nursing Final Order, dated June 11, 2008, is attached and incorporated, by reference, as a part of this pleading

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of revocation of Respondent's license to practice nursing in the State of Texas pursuant to the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to § 301.461, TEX. OCC. CODE ANN. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.state.tx.us.

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CONTINUED ON NEXT PAGE.

NOTICE IS GIVEN that to the extent applicable, based on the Formal Charges, the Board will rely on Adopted Disciplinary Sanction Policies for Lying and Falsification which can be found at the Board's website, www.bon.state.tx.us.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order which is attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Louisiana State Board of Nursing Final Order dated June 11, 2008.

Filed this 2nd day of July, 2009.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Renee Koslan Abel, Assistant General Counsel
State Bar No. 24036103
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6824
F: (512) 305-8101 or (512)305-7401

Attachments: Louisiana State Board of Nursing Final Order dated June 11, 2008.

0999/D

Louisiana State Board of Nursing

17373 Perkins Road
Baton Rouge, LA 70810
Telephone: (225) 755-7500 Fax: (225) 755-7582
www.lsbn.state.la.us

Certified Mail/Return Receipt Requested

April 17, 2008

Ms. Karen Morrow Glash
2003 Shannon Road
Alexandria, La 71301

Dear Ms. Glash:

It has come to the attention of the Louisiana State Board of Nursing that you have been involved with incidents which could affect patient safety, specifically:

1. From April 4, 2006 through March 4, 2008, while employed as a Registered Nurse at Dubuis Hospital in Alexandria, Louisiana, you exhibited a strong pattern of absences resulting in disciplinary counseling on February 27, 2007, June 6, 2007, November 2, 2007, a written reprimand on January 11, 2008.
2. From about January 25, 2008 through February 5, 2008, while employed as Registered Nurse in the Intensive Care Unit at Dubuis Hospital in Alexandria, Louisiana, you demonstrated numerous medication administration discrepancies specifically:
    a. On or about January 28, 2008, for patient #1 with pneumonitis, you
        - Failed to administer the 2100 dose of Baclofen, documented administration of the 0500 dose but failed to remove the medication from the Pyxis.
        - Documented administration of Ascorbic Acid at 2100 but did not remove the medication from the Pyxis until 0136.
        - Documented administration of the 0600 dose of Lactulose but failed to remove the dose from the Pyxis.
        - Failed to document administration of Percocet but removed the medication from the Pyxis at 0138.
        - Documented administration of Valium 5 mg at 2100 but did not remove the medication from the Pyxis until 0138.
    b. On January 29-30, 2008 for Patient #2, with orders for Q1 hr. Accuchecks and an Insulin Drip, you failed to perform hourly Accuchecks, documented two in a 12 hour shift at 0000 and 0600.
    c. On February 2-3, 2008, for Patient #3 with respiratory failure, you
        - Documented administration of Elavil 25mg at 2100 but did not remove the medication from the Pyxis.
        - Failed to document administration of Hydrocodone 10mg which was ordered Q 6 hrs PRN pain and removed Hydrocodone 10mg at 0239 and then again at 0418 and 0430 which was earlier than ordered.

- Removed Xanax 0.5mg without an order and failed to account for the medication.

d. On February 3-4, 2008, for Patient #4, who was on dialysis, you
   - Failed to perform hourly Accuchecks as ordered, and only documented blood glucose values at 2300 and 0045 for a 12 hour shift.
   - Removed Lexapro 10mg from the Pyxis at 2150 when the order was for Lexapro 20mg at 0900 and failed to account for the medication.
   - Removed Reglan 10mg at 2152 without an order and failed to account for the medication.
   - Removed 2 tablets of Ultracet at 0004 after removing 2 tablets at 2251 which was earlier than ordered since the order was for 2 tablets Q 6 hrs and failed to document administration of any Ultracet.
   - Documented administration of Vancomycin 250mg enema at 0000 and 0600, but failed to remove the medication from the refrigerator.

3. On April 14, 2008, you failed to cooperate with the Board by failing to provide a requested written explanation for the aforementioned incidents contained in a letter sent by certified and regular mail on March 25, 2008 to Respondent's address of record.

Grounds for disciplinary proceedings against a registered nurse are specified in La. R.S. 37:921 and authorizes the Board to probate, limit, restrict or revoke any license issued to Respondent on any of the following grounds:

- Respondent is unfit or incompetent by reason of negligence, habit, or other cause; La. R.S. 37:921(3);
- Respondent has violated any provision of this Part. La. R.S. 37:921 (9);
- Respondent failed to practice nursing in accordance with the legal standards of nursing practice; L.A.C. 46:XLVII.3405 (a);
- Respondent failed to utilize appropriate judgment; L.A.C. 46:XLVII.3405 (c);
- L.A.C. 46:XLVII.3405 (g);
- Respondent misappropriated items of an individual, agency, or entity; L.A.C. 46:XLVII.3405 (i);
- Respondent falsified records; L.A.C. 46:XLVII.3405 (j);
- Respondent demonstrated failure to act, or negligently or willfully committing any act that adversely affects the physical or psychosocial welfare of the patient; L.A.C. 46:XLVII.3405 (k);
- Respondent has violated a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of professional nursing, or a state or federal narcotics or controlled substance law; L.A.C. 46:XLVII.3405 (p);
- Respondent demonstrated inappropriate, incomplete or improper documentation; L.A.C. 46:XLVII.3405 (q);
- Respondent failed to cooperate with the board by:
  - not furnishing in writing a full and complete explanation covering a matter requested by the board L.A.C. 46:XLVII.3405 (s).

La. R.S. 37:925 authorizes the Board to impose a fine of up to $5,000.00 for each count or separate offense and to assess all costs of the proceedings including but not limited to the costs of investigation and disciplinary proceedings.

The health, safety, and welfare of the citizens of Louisiana are threatened by this conduct. The seriousness of this conduct constitutes a threat to the safety of patients and to allow nursing practice

in Louisiana to continue in light of the above would constitute a serious risk and a violation of patient security. Since these allegations are directly related to safe patient care, the board has determined that summary suspension of your license to practice nursing in the state of Louisiana is in order.

Therefore, **your Louisiana RN license is summarily suspended and you are hereby directed to return your 2008 RN license to the Board of Nursing. Additionally, please provide a written statement in regards to these allegations and complete and return the enclosed employment questionnaire.**

Pursuant to the Louisiana Administrative Procedures Act, R.S. 49:961.C:

> If the agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

The Board will consider the matter of ratification of staff action to summarily suspend your license at the next administrative hearing set for June of 2008. The meeting will be held at the Office of the Board, 17373 Perkins Road, Baton Rouge, Louisiana. You may appear at that hearing.

The Board will file a formal complaint for further action and schedule you to appear before the next scheduled Board meeting for an administrative hearing. That hearing is scheduled for **June 9-11, 2008**.

You are hereby requested to attend a **conference with Board Staff to discuss this situation on Thursday, May 1, 2008 at 2pm** in the Office of the Board at 17373 Perkins Road, Baton Rouge, Louisiana. Please call Danielle Smith, Regional Manager at (225) 755-7540 to confirm your appointment.

LOUISIANA STATE BOARD OF NURSING

Barbara L. Morvant, RN, MN
Executive Director

BLM/ds

Enclosures

LOUISIANA STATE BOARD OF NURSING

IN THE MATTER OF KAREN MORROW GLASH

COMPLAINT

Barbara L. Morvant, acting in her official capacity as Executive Director of the Louisiana Board of Nursing ("Board"), with respect to the above entitled matter appears for the purpose of commencement of a Formal Hearing in accordance with La. R.S. 37:911, *et seq.* and respectfully represents:

1.

KAREN MORROW GLASH ("Respondent") was licensed as a Registered Nurse by examination on March 22, 1978.

2.

Respondent has violated La. R.S. 37:911, *et seq.* ("Nurse Practice Act"), and the Rules and Regulations promulgated pursuant thereto, as a result of the following facts:

A. From April 4, 2006 through March 4, 2008, while employed as a Registered Nurse at Dubuis Hospital in Alexandria, Louisiana, Respondent exhibited a strong pattern of absences resulting in disciplinary counseling on February 27, 2007, June 6, 2007, November 2, 2007, and a written reprimand on January 11, 2008.

I. Respondent was absent or tardy on a minimum of 39 occasions within a 20 month period as follows:

- April 4-5, 2006;
- May 9-14, 2006;
- June 20, 2006;
- June 27, 2006;
- July 9, 2006;
- August 9, 2006;
- September 27, 2006;
- October 2, 2006;
- October 10, 2006;
- October 17, 2006 (unexcused – no call/no show)
- January 1, 2007;
- January 10-11, 2007;
- January 24, 2007;
- January 29-30, 2007;
- February 4, 2007 (tardy);
- February 9, 2007 (tardy);

- February 18, 2007 (tardy);
- April 10, 2007 (tardy);
- April 19, 2007 (tardy);
- April 28, 2007 (tardy);
- April 29, 2007 (tardy);
- May 1, 2007 (unexcused – no call/no show);
- May 9, 2007 (tardy);
- May 12, 2007 (tardy);
- May 13, 2007 (tardy);
- May 17, 2007 (tardy);
- May 18, 2007 (tardy);
- June 19-29, 2007;
- September 7, 2007;
- September 11, 2007 (tardy);
- September 21, 2007 (tardy);
- October 4, 2007 (tardy);
- November 15, 2007;
- November 22, 2007 (tardy – 3)
- December 5, 2007 (tardy – 3)

B. From about January 25, 2008 through February 5, 2008, while employed as a Registered Nurse in the Intensive Care Unit at Dubuis Hospital in Alexandria, Louisiana, Respondent demonstrated numerous medication administration discrepancies specifically:

I. On or about January 28, 2008, for Patient #1 with pneumonitis, Respondent,

- Failed to administer the 2100 dose of Baclofen, documented administration of the 0500 dose but failed to remove the medication from the Pyxis.
- Documented administration of Ascorbic Acid at 2100 but did not remove the medication from the Pyxis until 0136.
- Documented administration of the 0600 dose of Lactulose but failed to remove the dose from the Pyxis.
- Failed to document administration of Percocet but removed the medication from the Pyxis at 0138.
- Documented administration of Valium 5 mg at 2100 but did not remove the medication from the Pyxis until 0138.

II. On January 29-30, 2008 for Patient #2, with orders for Q1hr. Accuchecks and an Insulin Drip, Respondent failed to perform hourly Accuchecks, documented two in a 12 hour shift at 0000 and 0600.

III. On February 2-3, 2008, for Patient #3 with respiratory failure, Respondent,

- Documented administration of Elavil 25 mg at 2100 but did not remove the medication from the Pyxis.

- Failed to document administration of Hydrocodone 10 mg which was ordered Q 6 hrs PRN pain and removed at 0239 and then again at 0418 and 0430 which was earlier that ordered.
- Removed Xanax 0.5 mg without an order and failed to account for the medication.

IV. On February 3-4, 2008, for Patient #4, who was on dialysis, Respondent,

- Failed to perform hourly Accuchecks as ordered, and only documented blood glucose values at 2300 and 0045 for a 12 hour shift.
- Removed Lexapro 10 mg from the Pyxis at 2150 when the order was for Lexapro 20 mg at 0900 and failed to account for the medication.
- Removed Reglan 10 mg at 2152 without an order and failed to account for the medication.
- Removed 2 tablets of Ultracet at 0004 after removing 2 tablets at 2251 which was earlier than ordered since the order was for 2 tablets Q 6 hrs and failed to document administration of any Ultracet.
- Documented administration of Vancomycin 250 mg enemas at 0000 and 0600, but failed to remove the medication from the refrigerator.

La. R.S. 37:921 authorizes the Board to probate, limit, restrict or revoke any license issued to Respondent. As a result of the facts above, Respondent has violated the Nurse Practice Act and the Rules and Regulations promulgated thereunder, specifically:

a. Respondent is unfit or incompetent by reason of negligence, habit, or other cause; La. R.S. 37:921(3);

b. Respondent has violated any provision of this Part. La. R.S. 37:921 (9);

c. Respondent failed to practice nursing in accordance with the legal standards of nursing practice; L.A.C. 46:XLVII.3405 (a);

d. Respondent failed to utilize appropriate judgment; L.A.C. 46:XLVII.3405 (c);

e. Respondent misappropriated items of an individual, agency, or entity; L.A.C. 46:XLVII.3405 (i);

f. Respondent falsified records; L.A.C. 46:XLVII.3405 (j);

g. Respondent failed to act, or negligently or willfully committed an act that adversely affects the physical or psychosocial welfare of the patient); L.A.C. 46:XLVII.3405 (k);

h. Respondent has violated a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of professional nursing, or a state or federal narcotics or controlled substance law; L.A.C. 46:XLVII.3405 (p);

i. Respondent demonstrated inappropriate, incomplete or improper documentation; L.A.C. 46:XLVII.3405 (q);

j. Respondent failed to cooperate with the board by:
not furnishing in writing a full and complete explanation covering a matter requested by the board; L.A.C. 46:XLVII.3405 (s).

3.

La. R.S. 37:925 authorizes the Board to impose a fine of up to $5,000.00 for each count or separate offense and to assess all costs of the proceedings including but not limited to the costs of investigation and disciplinary proceedings.

LOUISIANA STATE BOARD OF NURSING

By: Barbara L. Morvant
Barbara L. Morvant, MN, RN
Executive Director

Sworn to an subscribed before me, this 17th day of April, 20 08 in Baton Rouge, Louisiana.

Joy A. Peterson
Joy A. Peterson LA Bar #19101
NOTARY PUBLIC

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:	*	
KAREN MORROW GLASH	*	**FINAL ORDER**
2003 SHANNON ROAD	*	
ALEXANDRIA, LA 71301	*	
RESPONDENT	*	

The Louisiana State Board of Nursing, having set a hearing to determine whether cause exists under LA R.S. 37:911, et seq., to revoke, suspend or otherwise discipline the license of **KAREN MORROW GLASH,** held said hearing on **June 10, 2008,** pursuant to applicable Louisiana laws and regulations.

A quorum of the Board was present. Celia Cangelosi, attorney, represented the Board and served as counsel to the President. E. Wade Shows, attorney, served as prosecuting attorney for the Board. Respondent was not present and was not represented by counsel at this hearing.

Testimony and other evidence were received by the Board, and as a result thereof, the Board makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. KAREN MORROW GLASH ("Respondent") was licensed as a Registered Nurse by examination on March 22, 1978.
2. On March 25, 2008, a demand letter was sent to Respondent's address of record by certified mail; on April 16, 2008, the certified mailing was returned unclaimed to the board office.
3. On April 17, 2008, Respondent's license was summarily suspended. Notice of summary suspension was mailed to Respondent's address of record by certified mail; on May 12, 2008, the mailing was returned unclaimed to the board office. On May 14, 2008, the notice of summary suspension was mailed to Respondent's address of record by regular first class mail.
4. On April 17, 2008, formal charges were filed against Respondent. Charges and notice of board hearing were mailed to Respondent's address of record by certified mail; on May 12, 2008, the mailing was returned unclaimed to the board office. On May 14, 2008, the notice of summary suspension was mailed to Respondent's address of record by regular first class mail.
5. On June 2, 2008, a second notice of board hearing was mailed to Respondent's address of record by regular first class mail.
6. Respondent has violated La. R.S. 37:911, et seq. ("Nurse Practice Act"), and the Rules and Regulations promulgated pursuant thereto, as a result of the following facts:

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:	*	
KAREN MORROW GLASH	*	**FINAL ORDER**
2003 SHANNON ROAD	*	
ALEXANDRIA, LA 71301	*	
RESPONDENT	*	

A. From April 4, 2006 through March 4, 2008, while employed as a Registered Nurse at Dubuis Hospital in Alexandria, Louisiana, Respondent exhibited a strong pattern of absences resulting in disciplinary counseling on February 27, 2007, June 6, 2007, November 2, 2007, and a written reprimand on January 11, 2008.
* Respondent was absent or tardy for a minimum of 39 occasions within a 20 month period:

April 4-5, 2006;
May 9-14, 2006;
June 20, 2006;
June 27, 2006;
July 9, 2006;
August 9, 2006;
January 10-11, 2007;
January 24, 2007;
January 29-30, 2007;
February 4, 2007 (tardy);
February 9, 2007 (tardy);
February 18, 2007 (tardy);
April 10, 2007 (tardy);
April 19, 2007 (tardy);
April 28, 2007 (tardy);
April 29, 2007 (tardy);
May 1, 2007 (unexcused - no call/no show);
May 9, 2007 (tardy);
September 27, 2006;
October 2, 2006;
October 10, 2006;
October 17, 2006 (unexcused-no call/no show)
January 1, 2007;
May 12, 2007 (tardy);
May 13, 2007 (tardy);
May 17, 2007 (tardy);
May 18, 2007 (tardy);
June 19-29, 2007;
September 7, 2007;
September 11, 2007;
September 21, 2007;
October 4, 2007 (tardy);
November 15, 2007;
November 22, 2007 (tardy - 3); and
December 5, 2007 (tardy - 3).

B. From about January 25, 2008 through February 5, 2008, while employed as a Registered Nurse in the Intensive Care Unit at Dubuis Hospital in Alexandria, Louisiana, Respondent demonstrated numerous medication administration discrepancies specifically:
* On or about January 28, 2008, for Patient #1 with pneumonitis, Respondent,
- Failed to administer the 2100 dose of Baclofen, documented administration of the 0500 dose but failed to remove the medication from the Pyxis.
- Documented administration of Ascorbic Acid at 2100 but did not remove the medication from the Pyxis until 0136.

IN THE MATTER OF:	*	
KAREN MORROW GLASH	*	**FINAL ORDER**
2003 SHANNON ROAD	*	
ALEXANDRIA, LA 71301	*	
RESPONDENT	*	

- Documented administration of the 0600 dose of Lactulose but failed to remove the dose from the Pyxis.
- Failed to document administration of Percocet but removed the medication from the Pyxis at 0138.
- Documented administration of Valium 5 mg at 2100 but did not remove the medication from the Pyxis until 0138.

* On January 29-30, 2008 for Patient #2, with orders for Q1hr. Accuchecks and an Insulin Drip, Respondent failed to perform hourly Accuchecks, documented two in a 12 hour shift at 0000 and 0600.
* On February 2-3, 2008, for Patient #3 with respiratory failure, Respondent,
  - Documented administration of Elavil 25 mg at 2100 but did not remove the medication from the Pyxis.
  - Failed to document administration of Hydrocodone 10 mg which was ordered Q 6 hrs PRN pain and removed at 0239 and then again at 0418 and 0430 which was earlier that ordered.
  - Removed Xanax 0.5 mg without an order and failed to account for the medication.
* On February 3-4, 2008, for Patient #4, who was on dialysis, Respondent,
  - Failed to perform hourly Accuchecks as ordered, and only documented blood glucose values at 2300 and 0045 for a 12 hour shift.
  - Removed Lexapro 10 mg from the Pyxis at 2150 when the order was for Lexapro 20 mg at 0900 and failed to account for the medication.
  - Removed Reglan 10 mg at 2152 without an order and failed to account for the medication.
  - Removed 2 tablets of Ultracet at 0004 after removing 2 tablets at 2251 which was earlier than ordered since the order was for 2 tablets Q 6 hrs and failed to document administration of any Ultracet.
  - Documented administration of Vancomycin 250 mg enemas at 0000 and 0600, but failed to remove the medication from the refrigerator.

CONCLUSIONS OF LAW

1. La. R.S. 37:921 authorizes the Board to probate, limit, restrict or revoke any license issued to Respondent.

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:	*	
KAREN MORROW GLASH	*	**FINAL ORDER**
2003 SHANNON ROAD	*	
ALEXANDRIA, LA 71301	*	
RESPONDENT	*	

2. Respondent was properly notified of the charges and date of hearing.
3. Based on the foregoing Findings of Fact, Respondent did violate LA R..S. 37:921 as set forth in the Complaint as filed, including, but not limited to the following subsections:
   - Respondent has violated any provision of this Part. La. R.S. 37:921 (9);
   - Respondent is unfit or incompetent by reason of negligence, habit, or other cause; La. R.S. 37:921(3);
   - Respondent failed to practice nursing in accordance with the legal standards of nursing practice; L.A.C. 46:XLVII.3405 (a);
   - Respondent failed to utilize appropriate judgment; L.A.C. 46:XLVII.3405 (c);
   - Respondent failed to cooperate with the board by:
     not furnishing in writing a full and complete explanation covering a matter requested by the board; L.A.C. 46:XLVII.3405 (s);
   - Respondent falsified records; L.A.C. 46:XLVII.3405 (j);
   - Respondent failed to act, or negligently or willfully committed an act that adversely affects the physical or psychosocial welfare of the patient); L.A.C. 46:XLVII.3405 (k);
   - Respondent has violated a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of professional nursing, or a state or federal narcotics or controlled substance law; L.A.C. 46:XLVII.3405 (p);
   - Respondent demonstrated inappropriate, incomplete or improper documentation; L.A.C. 46:XLVII.3405 (q);

4. That the evidence presented constitutes sufficient cause pursuant to LA R.S. 37:921 to suspend respondent's license to practice as a registered nurse in Louisiana. This is a public record and will be reported to the Healthcare Integrity and Protection Data Bank **(HIPDB) as E3: Filing False Reports or Falsifying Records, 52: Failure to Provide Medically Reasonable and/or Necessary Items or Services, H1: Narcotics Violation or Other Violation of Drug Statutes, Unauthorized Dispensing of Medication.**

HIPDB Narrative: RN exhibited a pattern of removing medications including narcotics that were not ordered or more frequently than ordered and failed to account for these medications. RN also documented administration of medications that were not given.

LOUISIANA STATE BOARD OF NURSING
BATON ROUGE, LOUISIANA

IN THE MATTER OF:	*	
KAREN MORROW GLASH	*	**FINAL ORDER**
2003 SHANNON ROAD	*	
ALEXANDRIA, LA 71301	*	
RESPONDENT	*	

ORDER

In an open meeting of the Louisiana State Board of Nursing, on **June 11, 2008**, the following order was rendered:

It is ORDERED, ADJUDGED, AND DECREED that the Board ratify the summary suspension by staff against this individual as the Board finds that the public health, safety, and welfare required this emergency action. Further, license shall remain suspended and Respondent shall not be able to request reinstatement until completion of the following stipulations.

1. Immediately surrender current RN license to Board staff to be retained in the registrant's file.
2. Refrain from working in any capacity as a Registered Nurse. Failure to do so shall cause further disciplinary action and/or criminal charges.
3. Submit to out-patient psychiatric, psychological and substance abuse evaluations by a psychiatrist, clinical psychologist and addictionist who have been approved by the Board; Shall authorize and cause a written report of the said evaluations to be submitted to the Board; Shall include the entire evaluation report including diagnosis, course of treatment, prescribed or recommended treatment, prognosis, and professional opinion as to registrant's capability of practicing nursing with reasonable skill and safety to patients.
4. Immediately submit to all recommendations thereafter of the therapist, physician, or treatment team, and cause to have submitted evidence of continued compliance with all recommendations by the respective professionals. This stipulation shall continue until the registrant is fully discharged by the respective professionals and until approved by the Board staff.
5. If found to be chemically dependent, immediately sign an agreement with the Recovering Nurse Program for a minimum of five (5) years, and cause to have submitted evidence of compliance with all program requirements for a minimum of one (1) year, prior to requesting reinstatement.
6. Submit payment of $500.00 fine to the Board.
7. Submit payment of $450.00 cost to the Board.
8. Not have any misconduct, criminal violations or convictions, or violations of any health care regulations reported to the Board related to this to any other incidents.
9. After completion of above, Respondent may meet with Board or Board staff and request license reinstatement and to present evidence to show cause as to why Respondent should be allowed to practice as a Registered Nurse. If approved for license reinstatement,