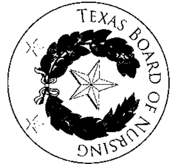

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 678829 and	§	
Vocational Nurse License	§	
Number 167908 issued	§	
to KATHLEEN KAREN BELL	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as Board, produced evidence indicating that KATHLEEN KAREN BELL, hereinafter referred to as Respondent, Registered Nurse License Number 678829 and Vocational Nurse License Number 167908, may have violated Sections 302.402(a)(10) and 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on August 26, 2008, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person and was represented by Nancy Roper Willson, Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; John F. Legris, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Noemi Vezina, Investigator; Christen Werley, Investigator; and Erin Menefee, Investigator.

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 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; and Respondent holds a license to practice vocational nursing in the State of Texas which is in delinquent status.

4. Respondent received a Certificate in Vocational Nursing from North Central Kansas Technical College, Beloit, Kansas, on June 21, 1996. Respondent was licensed to practice vocational nursing in the State of Texas on July 15, 1998. Respondent received an Associate Degree in Nursing from Kilgore College, Kilgore, Texas, on May 4, 2001. Respondent was licensed to practice professional nursing in the State of Texas on July 10, 2001.

5. Respondent's professional and vocational nursing employment history includes:

06/96 - 06/97	Licensed Vocational Nurse (LVN)	Kansas Home Health Care
07/97 - 1998	LVN	Heritage Nursing Home Quitman, Texas
1998 - 01/01	Unknown	
02/01 - 02/01	LVN, as needed	East Texas Medical Center Quitman, Texas
03/01 - 04/01	Unknown	
05/01 - 06/01	Graduate Nurse	East Texas Medical Center Quitman, Texas
07/01 - 05/06	Registered Nurse (RN), Charge Nurse, & House Supervisor	East Texas Medical Center Quitman, Texas
06/06 - 11/06	Director of Nursing (DON)	Van Health Care Center Van, Texas
12/06	Unknown	
01/07 - 06/07	DON	Green Acres Nursing Emory, Texas
02/07 - Present (periodic intervals)	RN - Temporary Nursing	Capstone Tyler, Texas
07/07 - 09/07	Assistant DON	Trinity Mission Winnsboro, Texas
03/08 - Present	RN	Community Health Clinics of NE Texas Tyler, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with East Texas Medical Center, Quitman, Texas, and had been in this position for two (2) years and four (4) months.

7. On or about November 10, 2003, while employed with East Texas Medical Center Regional Healthcare System, Quitman, Texas, Respondent misappropriated Rocephin, Decadron, Solumedrol, Effexor and Zomig from the facility and patients thereof. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.

8. On or about March 7, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent administered Lisinopril 20mg to Patient Medical Record Number 228889, instead of 40mg 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.

9. On or about March 7, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent falsely documented that she administered Lisinopril 40mg to the aforementioned Patient Medical Record Number 228889 in the patient's Medication Administration Record (MAR). Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation and would not have accurate information on which to base their decisions for further care.

10. On or about March 7, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent administered Potassium Chloride 10mg to the aforementioned Patient Medical Record Number 228889, instead of 20mg 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.

11. On or about March 7, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent falsely documented that she administered Potassium Chloride 20mg to the aforementioned Patient Medical Record Number 228889 in the patient's Medication Administration Record (MAR). Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation and would not have accurate information on which to base their decisions for further care.

12. On or about March 31, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent removed Premarin 0.625mg from the Pyxis Medication Dispensing System for Patient Medical Record Number 236502 without a physician's order. Respondent's conduct was likely to injure the patient in that the administration of Premarin without a physician's order could result in the patient suffering from adverse reactions.

13. On or about March 31, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent withdrew Premarin 0.625mg from the Pyxis Medication Dispensing System for the aforementioned Patient Medical Record Number 236502, as outlined above, but failed to document wastage of any unused portion of the medication, as required. Respondent's conduct was likely to deceive the hospital pharmacy.

14. On or about April 9, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent administered Zithromax to Patient Medical Record Number 243313 in excess dosage of the physician's order, in that the order was for 1/4 tsp po daily and Respondent administered ½ tsp during her shift. Respondent's conduct was likely to injure the patient in that the administration of Zithromax in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.

15. On or about August 24, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent failed to administer Ancef 1g IV to Patient Medical Record Number 208977 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.

16. On or about September 16, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent failed to administer Azactam 1g to Patient Medical Record Number 203848, 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.

17. On or about September 19, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent failed to administer Synthroid 50mcg to Patient Medical Record Number 243044, 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.

18. On or about September 26, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent removed Aspirin 325mg, Protonix 40mg, Thiamine 100mg/ml, Normal Saline 1000ml and Multivitamin 10ml vial from the Pyxis Medication Dispensing System, which were ordered for Patient Medical Record Number 247598, under the identification of Patient Medical Record Number 246549. Respondent's conduct resulted in Patient Medical Record Number 246549 getting charged for inappropriate medications which he/she did not receive.

19. On or about November 24, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent administered a Duragesic 50mcg/hr transdermal patch to Patient Medical Record Number 20-90-68 for whom there was no physician's order. Respondent's conduct was likely to injure the patient in that the administration of Fentanyl without a physician's order could result in the patient suffering from adverse reactions.

20. On or about November 24, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent failed to administer a Duragesic 50mcg/hr transdermal patch to Patient Medical Record Number 22-43-16, 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.

21. On or about November 24, 2005, while employed with East Texas Medical Center, Quitman, Texas, Respondent falsely documented that she administered a Duragesic 50mcg/hr transdermal patch to the aforementioned Patient Medical Record Number 22-43-16. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation and would not have accurate information on which to base their decisions for further care.

22. On or about January 6, 2006, while employed with East Texas Medical Center, Quitman, Texas, Respondent falsely documented that she administered Levsin 0.125mg to Patient Medical Record Number 254559 in the Medication Administration Record (MAR). Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation and would not have accurate information on which to base their decisions for further care.

23. In response to the incidents in Findings of Fact Numbers Nineteen (19), Twenty (20) and Twenty-One (21), Respondent states:

    "I do recall being 'pulled' from room 2A-B to room 3A-B several times before lunch. One of these ladies I had taken care of several different times through the years. It was devastating to me to learn that I had done this to a lady whom I had grown so fond of. The other lady I felt bad about as well... I just feel horrible it all happened period.
    After I was notified of the medication errors that I had made I asked my director of nursing two different times if I could temporarily be removed from the floor. She told me that she had no where else to place me."

    Respondent also submitted the following letters of recommendation and performance evaluations:

    - Three (3) letters of recommendation from Rosa Vasquez, RN, Head Nurse/ Woman's Health Clinic; Dana Nichols, General Manager, Capstone Personnel Staffing; and Mary Anne Fitzgerald, RNC;
    - A three (3) month employee performance evaluation from Community Health Clinics of Northeast Texas, Tyler, Texas, dated July 18, 2008, indicating an overall rating of "Satisfactory;" and
    - A Performance Evaluation from Capstone Healthcare Staffing, dated August 20, 2008, indicating an overall rating of "Above Standard", with a documentation rating of "standard."

24. On or about January 12, 2008, Respondent successfully completed a Board approved course in Texas Nursing Jurisprudence & Ethics, which would have been a requirement of this Order.

25. Formal Charges were filed on July 2, 2008.

26. Formal Charges were mailed to Respondent on July 3, 2008.

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 302.402(a)(10) and Section 301.452(b)(10)&(13), Texas Occupations Code; and 22 TEX. ADMIN. CODE §§ 239.11(1), 217.11(1)(A),(B),(C)&(D) and 217.12(1)(A),(1)(B),(1)(C), (4),(6)(A),(10)(B),(10)(C)&(11)(B).

4. The evidence received is sufficient cause pursuant to, Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 678829 and Vocational Nurse License Number 167908, heretofore issued to KATHLEEN KAREN BELL, including revocation of Respondent's licenses 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 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 privileges, if any, to practice nursing in compact states.

IT IS FURTHER AGREED and ORDERED that while Respondent's licenses are 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 licenses issued to KATHLEEN KAREN BELL, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order for appropriate notation.

(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. 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 physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. 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. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. 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://www.learningext.com/products/generalce/critical/ctabout.asp.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A REGISTERED NURSE OR LICENSED VOCATIONAL 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 REGISTERED NURSE (RN) OR 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 licenses. 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 licenses. 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 Registered Nurse or Licensed Vocational Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional 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 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 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.

(11) RESPONDENT SHALL undergo a (neuro-) psychological evaluation. The evaluation shall be performed by a Board certified psychiatrist or psychologist approved by the Board for the evaluation of Adult Attention Deficit Disorder or other such diagnosis as may be supported by the evaluation. The evaluation shall be completed within ninety (90) days from the date of this Order. RESPONDENT SHALL CAUSE the performing psychiatrist to send a report of the evaluation to the Board office. The report shall include:

1. A description of the instruments used for evaluation and the results of the evaluation;

2. A statement as to the RESPONDENT's fitness to safely practice professional nursing; and

3. Recommendations for therapy or other follow-up.

RESPONDENT SHALL comply with the recommendations for therapy or other follow-up. If the evaluation states that Respondent lacks fitness to practice professional or vocational nursing, RESPONDENT SHALL cease to provide direct patient care until such time that the same evaluator deems Respondent safe to return to direct patient care. When and if RESPONDENT is allowed to return to direct patient care, she will comply with the probationary stipulations outlined in this Order. If the results of the evaluation reveal further violations of the Nursing Practice Act, further disciplinary action may be taken, including revocation of Respondent's license to practice professional or vocational nursing in the State of Texas.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued unencumbered licenses and multistate licensure privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

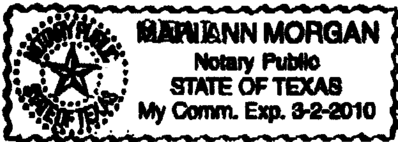
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid 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 licenses to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 10 day of October, 2008.

Kathleen K Bell

KATHLEEN KAREN BELL, Respondent

Sworn to and subscribed before me this 10 day of October, 2008.



Mari Ann Morgan

Notary Public in and for the State of Texas

Approved as to form and substance.

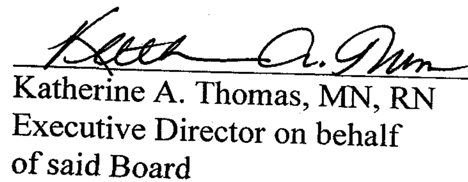
Nancy Roper Willson

Nancy Roper Willson, Attorney for Respondent

Signed this 12th day of May, 2009

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 10th day of October, 20 08, by KATHLEEN KAREN BELL, Registered Nurse License Number 678829 and Vocational Nurse License Number 167908, and said Order is final.

Effective this 9th day of June, 20 09.



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