Arkansas Department of Health

Arkansas State Board of Nursing
1123 S. University Ave., #800 • Little Rock, Arkansas 72204 • (501) 686-2700 • Fax (501) 686-2714
Governor Asa Hutchinson
José R. Romero, MD, Secretary of Health
Sue A. Tedford, MNSc, APRN, Director

BOARD MEETING MINUTES

TIME AND PLACE: April 6, 2022
Board Conference Room

MEMBERS PRESENT: Lance Lindow, RN; Neldia Dycus, BS, MHSM, MHRD, RN; Janice Ivers, MSN, RN, CNE; Stacie Hipp, APRN; Jasper Fultz, LPN; Melanie Garner, LPN, CLC; Yolanda Green, LPN; Ramonda Housh, MNSc, APRN, CNP, C-PNP

MEMBERS ABSENT:

STAFF ATTENDING AT VARIOUS TIMES:
Sue A. Tedford, Director, MNSc, APRN
David Dawson, JD, General Counsel
Ashley Fisher, Attorney Specialist
Lisa Wooten, Assistant Director, MPH, BSN, RN
Karen McCumpsey, Assistant Director, MNSc, RN, CNE
Shannon McKinney, Assistant Director, DNP, APRN, WHNP-BC
Tammy Vaughn, Program Coordinator, MSN, RN, CNE
Aaron Singleton, Regulatory Board Chief Investigator
Leslie Suggs, Executive Assistant to the Director
Susan Moore, Computer Operator
Mindy Darner, Legal Support Specialist
Lisa Mendenhall, Legal Support Specialist

GUESTS ATTENDING: Mary Kennebrew, Office of Attorney General

President Lance Lindow called the meeting to order at 8:34 a.m. Guests were welcomed and a flexible agenda was approved.

DISCIPLINARY HEARINGS
General Counsel, David Dawson, and Ashley Fisher, Attorney Specialist, represented the Board. Motions reflect the decisions of the Board reached in deliberation following the hearing of each case.

TIFFANY FIELD, LICENSE NO. R094891
Respondent was present for the proceedings before the Board and was represented by counsel, Darren O'Quinn. Lisa Wooten, MPH, BSN, RN, Penny Summers, RN, Bendi Bowers, MSN, RN, and Kaleena Sherbett, RN, provided testimony on behalf of the Board. Ashley Jeffry, RN, Jeffrey Hampton, RN (via phone), Brandi Antonsen, RN, and Savannah Thackeray, RN, provided testimony for the Respondent. Respondent has been charged with Ark. Code Ann. § 17-87-309(a)(6) and (a)(9) and pleads not guilty to the charges. Respondent holds Arkansas RN License No. R094891. An investigation was prompted by an anonymous letter written on March 14, 2019. The letter stated that Respondent, while working at Baptist Health-North Little Rock, administered a lethal dose of Versed to a patient and disregarded

numerous safety steps and alarms during this process. On another occasion Respondent turned off a nitroglycerin drip (gtt) on a patient prior to surgery without a physician's order. This was done despite family asking for the medication to be continued. Respondent refused to restart the Nitro on three (3) separate occasions. This led to the patient's deterioration and subsequent death. The patient was in no acute distress prior to her actions. Respondent is reckless and violated multiple safety measures, in which, patients and families have paid the cost for her neglect. Respondent was hired by Baptist Health – North Little Rock on October 6, 2014. On March 1, 2019, Kaleena Sherbett, RN, Nursing Manager, indicated in a written statement regarding a Quality Assurance received on Versed gtt (for Patient-CG), that Respondent manually programmed the IV pump because the pump would not scan. The pump was programmed to 50ml/hr; however, the pump said 1mg/hr, which was what she was going by. Respondent was counseled on medication administration expectations and instructed if the pump was not scanning, then she was to find a new pump. Respondent's Scorecard Trend for patient and medication scanning indicated Respondent's scanning rate for January, was 92.97% for patient scanning and 92.43% for medication scanning, in February, patient scanning: 97.99%, medication scanning: 97.66%, and in March, patient scanning: 100%, and medication scanning: 100%. On April 22, 2019, Respondent was given a Written Counseling due to hanging a medication and bypassing the safety features of the pump, resulting in the medication being hung at an incorrect dose. Medication administration expectations were reviewed, including changing out the pump if the bar code will not scan. Respondent will meet 95% or greater for bar code scanning compliance for both medication and patient every month. Respondent will provide unit based education for the entire unit on the importance of using the Alaris pump integration by the end of April. A review of Patient CG's medical record indicates on February 28, 2019: At 18:35, Respondent documented on Medication Administration Record (MAR): starting midazolam (Versed) 1 mg/hr-(1 ml/hr), and at 19:42, David Larson, RN, documented on MAR hung new bag of midazolam (Versed) 1mg/ml. It should be noted, the bag of Versed Respondent hung at 18:35, should have lasted approximately ten (10) hours at the maximum rate ordered at 10 mg/hr; however, according to documentation on the MAR, the bag lasted approximately 67 minutes. This would indicate an effective rate of 89.605mg/hour. Kaleena Sherbett, RN, is Respondent's Nurse Manager. Ms. Sherbett indicated she was informed of the Versed incident the day after it happened. Respondent reported to Ms. Sherbett that Patient-CG had to have a rapid intubation and Respondent could not get the pump to scan, so she bypassed the safety feature and manually programmed the pump. Ms. Sherbett indicated the Versed was running next to the propofol and Respondent may have programmed the Versed at the propofol rate. The Versed was hung around 17:30, close to shift change. When the night shift nurse came on, they found the need to hang a new Versed bag. The patient had already been intubated and there was no change in the patient's vital signs. Ms. Sherbett indicated she was unaware of any complaints regarding a nitroglycerin drip, as stated in the complaint. On May 9, 2019, Kris Moody, RN contacted the investigator by telephone and the allegations of the investigation were discussed. Mr. Moody indicated the nitroglycerin and heparin incident happened approximately six (6) to eight (8) months ago. He could not remember the patient's name; however, he did remember the patient had to go back to surgery and passed away. Mr. Moody indicated that Kyndal Smith, RN was the nurse working with Respondent the day the Versed was hung and was a witness. On May 10, 2019, Kyndal Smith, RN, contacted the investigator and the allegations of the investigation were discussed. Ms. Smith indicated Patient-CG was intubated and the propofol was not controlling the patient's agitation. She indicated Respondent asked her (Ms. Smith) to call the doctor, which she did and got an order for Versed. Ms. Smith indicated she assisted Respondent getting the Versed out of the Pyxis in over-ride. Since they were removing the Versed in over-ride the Pyxis required a witness. Ms. Smith indicated this occurred during shift change, so after the Versed was removed from the Pyxis, she left Respondent to go into report. She did not witness Respondent hanging or programming the pump for the Versed. On May 20, 2019, David Larson, RN, contacted the investigator and the allegations of the investigation were discussed. Mr. Larson indicated after receiving report from Respondent, who stated Patient-CG had recently been intubated and placed on Versed 1mg/hour for sedation, the IV pump began alarming. Mr. Larson indicated the Versed was empty. After obtaining a new bag of Versed and attempting to scan the medication into Epic, he received an alert message. While checking the pump, Mr. Larson indicated he noticed the concentration

of the versed was entered as 2mg/100ml instead of 100mg/100ml. The pump was giving 1mg/hour as reported, but the concentration was incorrect thus giving 50mg/hour. Mr. Lawson alerted the charge nurse and continued to monitor the patient. Mr. Larson indicated he did not witness the incident involving the nitroglycerin allegation. On May 23, 2019, Jeffery Hampton, RN, contacted the investigator and the allegations of this investigation were discussed. Mr. Hampton indicated around the end of December, 2018 or the first of January, Respondent was caring for one of Dr. James Day's patients who was scheduled to have a Coronary Artery Bypass Graft (CABG) surgery. The surgery ended up getting delayed until the afternoon and Dr. Day ordered the patient's heparin drip to be stopped. Mr. Hampton indicated that the patient was stable and had been on heparin and nitroglycerin drips for at least two (2) days prior to surgery, without any reports of pain. Mr. Hampton indicated Respondent turned off the heparin and nitroglycerin drip. There was not an order to stop the nitroglycerin. Approximately fifteen (15) to twenty (20) minutes after turning off the nitroglycerin, the patient starting having chest pain. The family of the patient began asking Respondent to turn the nitroglycerin back on because the patient had been pain free prior to stopping the medication. Mr. Hampton indicated he told Respondent to get an electrocardiogram (EKG). Respondent refused. Mr. Hampton indicated the chest pains became worse and he again instructed Respondent to get an EKG. The EKG showed a large inferior myocardial infarction (MI) and possibly a septal MI also. There were ST elevations that were not there prior. Dr. Day was called and he ordered the patient be brought down to the Operating Room. Mr. Hampton indicated Dr. Day was unable to harvest the veins for the bypass due to the patient being too unstable. The patient ultimately died. Mr. Hampton indicated he has witnessed many deaths over the years working as a nurse, but this one bothered him. Mr. Hampton said Respondent didn't appear to show any remorse and would not take any kind of ownership. Mr. Hampton indicated he was not a witness to the Versed allegation. A review of Patient EE's medical record indicates, in part: On January 1, 2019, according to Jerson Mendoza, M.D., Patient-EE was scheduled for CABG (coronary artery bypass graph) in the am. No ischemic ECG changes. Started on nitro drip, on max dose of BB,(beta blocker). NPO after MN. At 10:30, James Day, M.D., ordered nitroglycerin 100mcg/ml, initiate and titrate: start infusion at 5mcg/min and increase by 5mcg/min every 5 minutes to a target SBP and DBP or max of 400mcg/min. Weaning; Decrease by 5mcg/min every 5 minutes to maintain target blood pressure. Discontinued on January 3, 2019 at 13:51 due to patient discharge, On January 2, 2019, at 06:43, Respondent assumed the care of PatientEE. At 07:00, Respondent documented no pain, At 09:18, Respondent documented changed rate on the MAR, nitroglycerin Rate/Dose: 5mcg/min, 3ml/hr, At 09:30, vital signs: pulse-70, respiratory-18, blood pressure-141/85, At 10:00, vital signs: pulse-83, respiratory-20, blood pressure-151/78, At 10:18, Respondent documented she called Alisa, APRN to evaluate when to turn off the heparin gtt. Response: turn off now. The MAR indicated Respondent stopped heparin, at 10:06, It should be noted, there is no nitroglycerin drip administration documented by Respondent from 09:18 to 10:42 and after 13:18. It should be noted; documentation was not located ordering the discontinuation of nitroglycerin in the medical record. Respondent, complainant and Jeffery Hampton, RN reported Respondent turned off the nitroglycerin drip when she stopped the heparin drip, At 10:42, Respondent documented verified on the MAR, nitroglycerin Rate/Dose: 5mcg/min, 3ml/hr, At 11:30, vital signs: pulse-68, respiratory-26. blood pressure-133/69, At 11:43, Respondent documented verified on the MAR, nitroglycerin Rate/Dose: 5mcg/min, 3ml/hr, At 13:14, Respondent documented on the MAR, new bag of nitroglycerin hung, 10mcg/min, 6ml/hr, At 13:15, Respondent documented: pt c/o 8/10 CP radiating down both arms. Nitro gtt infusing at 20mcg/min, 2L NC in place, EKG completed showing ST elevation in II, II, and AVF. Pain did not subside morphine 2mg administered. Additional RN paging both Dr. Caldwell and CV surgery. Pt states pain relief 4/10. Dr. Hogate at bedside. Dr. Caldwell retuned page, notified of events and 5,000-unit heparin bolus received and carried out. Pt noted to be in 3rd degree heart block prior to moving pt out of room to CVOR per instructions. AED pads applied to patient. AED mode in addition to bedside monitor used to monitor patient. Patient moved from CCU to OR1 at this time, and at 13:22, Patient-EE was transferred from CCU to the surgery department. Jay Geoghagan, M.D. indicated, in part, prior to going to the operating room, Patient-EE, suffered an acute ST segment elevation myocardial infraction involving the right coronary artery. She was taken emergently to the cardiac catheterization laboratory and underwent extensive coronary procedures. She had refractory no reflow phenomenon in the setting

of a history of a coagulation and platelet disorder. She was placed on multiple antiplatelet medications and was intubated. She then returned to the coronary care unit. During the evening, she declined. On January 3, 2019, at 04:00, she lost her pulse and ACLS protocols started. At 04:52am, she had no spontaneous respirations, no spontaneous cardiac activity, no pulse and was pronounced dead. Another complaint was received by ASBN on January 20, 2020 from Baptist Health Medical Center. The complaint indicates in part that the Respondent turned off a Vasopressin drip on Patient (W.B.) without an order from the physician or consent from the patient's family resulting in reckless and negligent behavior. Supporting documentation from Baptist Health Medical Center includes Termination Report for reasons of unsatisfactory performance and misconduct or violation of rules. Outlined expectations included the expectation to titrate medication as ordered by the physician. According to the Performance Management Decision Guide it was a deliberate act, in the fact that the respondent stated both in writing and verbally that she made the decision to not hang the next bag of Vasopressin and thought that the family would soon make the patient comfort care. Kristi Ferguson, RN reported that the Respondent stated, "I didn't see where the drip was doing any good anyway, so when it went dry I just didn't restart it. I had a new bag there, someone just needed to spike it. I told John he could. I never said it was dc'd. The family needs to know this isn't right, someone needs to tell them. I just didn't feel like it was right to keep doing that to her". Debra Langley, Director Inpatient Nursing interviewed John Barnett, RN about receiving report from the Respondent at the end of the 11/25/2019 shift. According to Barnett, the Respondent told him that the Vasopressin bag was empty and that she did not hang another bag. That it was not doing the patient any good and that her BP was ok. The Respondent's written response to Debra Langley, Director of Inpatient Nursing, stated in part that she explained to the oncoming nurse John that she had new bag to spike. She expressed that she did pause on spiking the Vasopressin drip earlier because she thought the family was going to officially make the patient comfort care and the patient was actively dying. According to Langley, Respondent admitted that she did not document additional nurse's note because of how busy she was. The termination report stated the Respondent departed from policies, procedures, and protocols by not following rules of titration outlined on medication administration record (MAR) and not following order of discontinuation outlined on MAR. MAR states, "If on multiple vasopressors, order of discontinuation (first to last) should be: Dopamine, phenyleprine, epinephrine, norepinephrine, Vasopressin". Supporting documentation also notes a trend in poor performance or decision making, citing a 2019 written counseling for failure to follow safety features on an IV pump causing a patient to receive an incorrect dose of medication. A Consent Agreement and Voluntary Surrender form were sent certified and regular mail after a second practice related complaint was received. The certified mail was signed for by an individual at the address on file with the ASBN on August 21, 2020. The regular mail was not returned. On September 7, 2020 Respondent sent an email to ASBN staff requesting a hearing before the Board.

The meeting recessed for lunch at 1:08 p.m. Following lunch, the Board resumed the hearing for Tiffany Field.

President Lance Lindow called the meeting to order at 1:48 p.m. A flexible agenda was approved.

> **MOTION:** I MOVE that based on the evidence presented and the allegations contained in the Order and Notice of Hearing, the Arkansas State Board of Nursing finds that **TIFFANY FIELD, LICENSE NO. R094891,** has been charged with a violation of Ark. Code Ann. § 17-87-309(a)(6) and (a)(9) and that Respondent's license and privilege to practice as a nurse be placed on probation for two (2) years with the following terms and conditions:
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> - Pursuant to A.C.A. §17-87-104(b)(1), Respondent shall pay a civil penalty of $4,300, plus any outstanding balance associated with previous disciplinary action. Such fine shall be payable within fifteen (15) days of receipt of this Order. If unable to pay the civil penalty within fifteen (15) days, a payment schedule shall be submitted within fifteen (15) days to the Board via email at ASBN.monitoring@arkansas.gov.

- Respondent shall provide evidence within six (6) months of successful completion of the Board approved course(s): *Documentation for Nurses, Patient Safety: A Critical Practice Concern, Sharpening Critical Thinking Skills, Anger Management, and Professional Accountability and Legal Liability for Nurses*. Respondent shall submit the certificate(s) of completion via email at ASBN.monitoring@arkansas.gov.
- Respondent shall submit the *Enforcement Personal Report* to the Board via the Board approved monitoring program quarterly.
- Respondent shall ensure that all reports, of Respondent and the employer, are submitted quarterly via the Board approved monitoring program.
- Respondent shall execute any release necessary to give the Board access to records including, but not limited to, medical, psychological, employment, and or criminal records. Failure to execute a release shall be grounds for additional disciplinary action against Respondent's license / privilege to practice.
- Respondent shall obey all federal, state, and local laws, and all rules governing the practice of nursing in this state.
- Respondent shall be responsible for all costs involved in complying with the Board's Order.
- Respondent is required to submit any change of information, even a temporary one, in name, address, or employer via the ASBN Nurse Portal within ten (10) days of the change.
- The Nurse Licensure Compact status of Respondent's Arkansas license shall be single state, allowing practice only in the State of Arkansas. Respondent may submit the *Multistate Conversion Application* after successful completion of probation to determine if license meets the Uniform Licensure Requirements (ULR) for multi-state compact status.
- Respondent shall notify and present to each employer a copy this Order if working as a nurse on probation. Respondent shall have employer sign the *Employer Acknowledgement* form. Respondent shall submit the document to the Board via the Board approved monitoring program. Respondent shall have their employer complete the *Performance Evaluation Report*. Respondent shall submit the report to the Board via the Board approved monitoring program quarterly or employer may email the report directly to the Board at ASBN.monitoring@arkansas.gov .
- Respondent shall work under supervision in any setting. Supervision requires another nurse at the same or higher education level, to be working in the same setting as Respondent and be readily available to provide assistance and intervention.
- Respondent shall not be employed in critical care, in-home hospice, or home health settings.
- Respondent shall not collect any drug screen specimen from a participant who has been ordered to drug screen by the Board of Nursing.
- Respondent shall request to the Board verification of termination of the probationary period and license reinstatement by submitting the *Reinstatement Request Form*, via the ASBN Nurse Portal once compliance with the Board's Order is met. Respondent is required to continue all monitoring requirements including but not limited to checking in daily for random drug screening, testing if selected, attending meetings, and submitting reports until released from the probation period by Board staff.
- Pursuant to Ark. Code Ann. §17-87-309, failure to comply with this Order may result in additional disciplinary action on the Respondent's licensure and/or privilege, including but not limited to, additional probation, suspension, or revocation of licensure and/or privilege to practice nursing in this state.

Brought by Janice Ivers and seconded by Yolanda Green.
PASSED

BRENDA NICOLE COONS HUBBARD, ENDORSEMENT APPLICANT

Respondent was present for the proceedings before the Board and was not represented by counsel. Karen McCumpsey, MNS, RN, CNE, provided testimony on behalf of the Board. Respondent has

requested a waiver of a criminal conviction bar, pursuant to A.C.A. 17-3-102(b). Respondent disclosed on her application for licensure by endorsement that she had plead guilty to Forgery 2nd Degree (5-37-201), a felony, and Failure to Appear, in Garland County Circuit Court, on May 9, 2017. She received forty-eight (48) months Community Corrections Probation. Respondent also plead guilty to Possession of Drug Paraphernalia (5-64-443), a felony, in Montgomery County Circuit Court, on September 5, 2017. Her previous probation was revoked, and she was incarcerated in the Arkansas Department of Corrections. Respondent served eleven (11) months. A.C.A. 5-64-443 – Possession of Drug Paraphernalia, is part of the Uniformed Controlled Substances Act. A.C.A. 17-3-102 (a)(32), bars an individual from holding a Nursing license if they have plead guilty or been found guilty of a felony violation of the Uniform Controlled Substances Act, unless the individual requests and receives a waiver pursuant to A.C.A. 17-3-102(b). A letter was sent to Respondent on September 7, 2021, denying Respondent's application for licensure by endorsement, pursuant to A.C.A. 17-3-102(a). The letter also explained the opportunity to request a waiver pursuant to A.C.A. 17-3-102(b). On September 26, 2021, Respondent sent a letter to Sue Tedford, ASBN Director, requesting a waiver of the criminal bar statute pursuant to A.C.A. 17-3-102(b). The letter also included additional information requested by Board staff.

> **MOTION:** I MOVE that based on the evidence presented and the allegations contained in the Order and Notice of Hearing, the Arkansas State Board of Nursing finds that **BRENDA NICOLE COONS HUBBARD, ENDORSEMENT APPLICANT,** pleaded guilty of nolo contendere to, or has been found guilty of a crime making them ineligible to hold a nursing license as cited in Arkansas Code Annotated §17-87-102, and §17-87-109(a)(2) and the Board grants a waiver of A.C.A. §17-3-102.

Brought by Ramonda Housh and seconded by Neldia Dycus.
PASSED

A motion is presented to the Board to refer applicant Brenda Nicole Coons Hubbard to the Arkansas Nurse Alternative to Discipline Program (ArNAP) prior to endorsement.

> **MOTION:** I MOVE that **BRENDA NICOLE COONS HUBBARD, ENDORSEMENT APPLICANT,** is referred to ArNAP prior to endorsement.

Brought by Janice Ivers and seconded by Yolanda Green.
PASSED

TERRA LYNETTE BURCHFIELD DUNN, LICENSE NO. R088409, L047441 (EXPIRED)

Respondent was not present for the proceedings before the Board and was not represented by counsel. Lisa Wooten, MPH, BSN, RN, provided testimony on behalf of the Board. Respondent holds Arkansas RN License No. R088409 and Arkansas LPN License L047441(Expired). The Board received a complaint on February 10, 2021, from Baptist Health, Little Rock, Arkansas reporting the Respondent's termination of employment for attempting to falsify her drug screen. On February 18, 2021, the Board received a second complaint from AMN Healthcare reporting the same issue. Respondent was employed by AMN Healthcare and began a contract with Baptist Health on January 25, 2021. Employment records from Baptist Health indicate that on January 29, 2021, Respondent was noted giving the incorrect information to the physician about her patient, had slurred speech, and appeared to be impaired. Respondent admitted to taking Benadryl the night before and a hydrocodone and Xanax the morning prior to reporting to work. Respondent was escorted to submit a specimen for a for cause drug screen. During the third attempt to submit a specimen, the observer noticed Respondent trying to pull something out of her bra. The observer saw Respondent pull a container out and attempt to put the contents in the cup. The observer retrieved the container and placed it in a bag. The container had a temperature gauge on it filled with clear yellow liquid. Respondent stated in part to the observer she carried the container of urine with her because she knew she shouldn't be taking medicine while working. Respondent was terminated. Respondent has been employed with AMN Healthcare since February 11, 2019. She completed all previous contracts. Respondent gave a statement to AMN Healthcare reporting that before work on

January 29, 2021, she had taken tramadol that was prescribed for a previous issue regarding injuries from an automobile accident. The reason she tampered with her urine was because she was scared and did not realize if she had a prescription the results may be negative. Pharmacy records of all controlled substance activity (both new and refill prescriptions) dispensed by three (3) pharmacies and five (5) providers for Respondent from September 26, 2019, to September 26, 2021, were requested. Respondent was dispensed: Twenty-five (25) prescriptions for alprazolam, totaling two thousand two hundred-fifty (2250) tablets, last filled on September 15, 2021. Seven (7) prescriptions for oxycodone, totaling five hundred (552) tablets, last filled on September 11, 2021. Nineteen (19) prescriptions for zolpidem, totaling four hundred-fifty (450) tablets, last filled on May 24, 2021. Three (3) prescriptions for phentermine, totaling ninety (90) tablets, last filled on May 14, 2021. Three (3) prescriptions for phentermine HCL powder, totaling 4.05gm, last filled on February 25, 2020. Eight (8) prescriptions for hydrocodone, totaling four hundred forty-four (444) tablets, last filled on April 6, 2021. Twenty-five (25) prescriptions for tramadol totaling one thousand five hundred (1500) tablets, last filled on December 9, 2020. Two (2) prescriptions for pregabalin, totaling sixty (60) tablets, last filled on March 25, 2020. Three (3) prescriptions for eszopiclone, totaling ninety (90) tablets, last filled on January 14, 2020. Respondent submitted to an addictive evaluation at the request of Board staff. Dr. Leach with New Dawn Counseling recommended the following: "The patient is currently diagnosable with an opioid use disorder, mild (rule out moderate) and sedative/hypnotic/anxiolytic use disorder, mild (rule out moderate), along with recurrent major depression and anxiety. Though the medications she has been using have been prescribed to her, the frequency and combination with which she takes them as well as the actions she has taken in past are concerning. It is my professional medical opinion based upon all collectible information gathered that the patient is currently not clear to practice in her specialty without restrictive parameters or restrictions at the time of this evaluation. I would agree with recommendations for: return to work evaluation upon completion of treatment of her leg wound, starting therapy, getting engage in substance use support groups, getting set with a psychiatrist to actively manage her medications and to follow with the psychiatrist regularly, to reduce and if possible eliminate both her use of Benzodiazepines and opioids, and to be monitored very closely when she is to return to work as a nurse pending completion of the these conditions under a period of probationary employment with standard random urine drugs screens. Until these items are addressed the patient would likely be unable to perform the duties requested of her as a nurse in a safe and effective manner. Respondent was offered a Consent Agreement. On October 29, 2021, Respondent contacted Board staff prior to her response deadline, indicated she wanted to have an attorney review the consent agreement. ASBN staff has received no communication from an attorney and has had no further communication from Respondent.

MOTION: I MOVE that based on the evidence presented and the allegations contained in the Order and Notice of Hearing, the Arkansas State Board of Nursing finds that **TERRA LYNETTE BURCHFIELD DUNN, LICENSE NO. R088409, L047441 (EXPIRED),** has been charged with a violation of Ark. Code Ann. § 17-87-309(a)(3), (a)(4), and (a)(6), and that Respondent's license and privilege to practice as a nurse be suspended two (2) years with the following terms and conditions:

- Pursuant to A.C.A. §17-87-104(b)(1), Respondent shall pay a civil penalty of $3,750.00, plus any outstanding balance associated with previous disciplinary action. Such fine shall be payable within fifteen (15) days of receipt of this Order. If unable to pay the civil penalty within fifteen (15) days, a payment schedule shall be submitted within fifteen (15) days to the Board via email at ASBN.monitoring@arkansas.gov.
- Respondent shall provide evidence within six months of successful completion of the Board approved course(s): *Substance Abuse Bundle, and The Nurse and Professional Behaviors.* Respondent shall submit the certificate(s) of completion via the Board approved monitoring program.
- Respondent shall attend AA/NA, or other Board approved support group meetings and shall submit quarterly reports to the Board through the Board approved monitoring program. Acceptable evidence shall consist of completion of the disciplinary form, *Aftercare Meetings*

Report. Respondent shall log attendance of all support group meetings via the Board approved monitoring program.

- Respondent shall attend at least three (3) AA/NA or other Board approved support group meeting(s) a week during the period of suspension and / or probation.
- Respondent shall obtain or continue counseling with a psychiatrist, psychologist, or other recognized mental health practitioner and shall submit the practitioner's progress report quarterly until discharged by the practitioner. Treatment shall begin within thirty (30) days of receipt of this Order.
- Respondent shall abstain at all times from the use of all controlled or abuse potential substances including alcohol, products that contain alcohol, all fermented products (i.e. kefir, kombucha tea, etc.), hemp, poppy seeds, cannabidiol (CBD), or any product or by-product containing the same. Short-term treatment (less than three (3) weeks) with a controlled medication may be allowed for an acute illness or acute condition with appropriate documentation (i.e. short-term waiver, medical record documentation, etc.). Respondent shall notify Board staff within ten (10) days of being prescribed a controlled or abuse potential substance via the Board approved monitoring program. Respondent shall log all medications, including over-the-counter medications via the Board approved monitoring program. Acceptable documentation must include the following information: prescriber, medication name, dose, date prescribed, and amount dispensed. Acceptable format of documentation includes photo(s) of the prescription label, documentation from the provider, or documentation from the pharmacy.
- Respondent shall submit to observed, random drug screens. The observed drug screens shall meet the criteria established by the Board and be conducted through a Board approved monitoring program, laboratory, and collection site. Respondent shall contact the monitoring program to activate their account and begin checking in daily beginning the first of the month following the Board Order. If selected for testing, Respondent shall submit the specimen within two (2) hours from the time of notification. Respondent shall not submit specimens at Respondent's place of employment or practice site. Failed drug screens include the results of a biological specimen, which is determined to be diluted, substituted, abnormal, adulterated, or tests positive for alcohol, controlled substances, abuse potential substances, or their metabolites without a valid prescription or failure to present and provide specimen when notified. Respondent shall notify the Board of any travel two (2) weeks prior to traveling by submitting a monitoring interruption via the Board approved monitoring program. Respondent shall continue to check in during travel period and test when selected. Travel outside the continental U.S. requires 30 days' notice. If approved, a waiver shall be issued during the travel period outside the continental U.S.
- Respondent shall not collect any drug screen specimen from a participant who has been ordered to drug screen by the Board.
- Respondent shall submit the *Enforcement Personal Report* to the Board via the Board approved monitoring program quarterly.
- Respondent shall ensure that all reports of Respondent and the employer are submitted quarterly via the Board approved monitoring program.
- Respondent shall execute any release necessary to give the Board access to records including, but not limited to, medical, psychological, employment, and or criminal records. Failure to execute a release shall be grounds for additional disciplinary action against Respondent's license / privilege to practice.
- Respondent shall obey all federal, state, and local laws, and all rules governing the practice of nursing in this state.
- Respondent shall be responsible for all costs involved in complying with the Board's Order.
- Respondent is required to submit any change of information, even a temporary one, in name, address, or employer via the ASBN Nurse Portal within ten (10) days of the change.

- If you fail to comply with the terms of suspension during the monitoring period, you may not restart the monitoring period until six (6) months after the date you were determined to be noncompliant.
- Respondent shall request to the Board verification of termination of the suspension period and license reinstatement to probation via the ASBN Nurse Portal or via the Board approved monitoring program once compliance with the Board's Suspension Order is met.
- A probation period of three (3) years shall follow the suspension period. All conditions of the suspension period regarding treatment programs, random drug screens, and abstinence shall continue through the probation period.
- While on probation, if working as a nurse, the Nurse Licensure Compact status of Respondent's Arkansas license shall be single state, allowing practice only in the State of Arkansas. Respondent may submit the *Multistate Conversion Application* after successful completion of probation to determine if license meets the Uniform Licensure Requirements (ULR) for multi-state compact status.
- Respondent shall notify and present to each employer a copy this Order if working as a nurse on probation. Respondent shall have employer sign the *Employer Acknowledgement* form. Respondent shall submit the document to the Board via the Board approved monitoring program. Respondent shall have their employer complete the *Performance Evaluation Report* and Respondent shall submit the report to the Board via the Board approved monitoring program quarterly.
- Respondent shall work under supervision in any setting. Supervision requires another nurse at the same or higher education level, to be working in the same setting as Respondent and be readily available to provide assistance and intervention. Respondent shall not be employed in critical care, in-home hospice, or home health settings.
- Respondent shall request verification of termination of the probationary period by submitting the Reinstatement Request form, via the ASBN Nurse Portal once compliance with the Board's Probation Order is met. Respondent is required to continue all monitoring requirements including, but not limited to, checking in daily for random drug screening, testing if selected, attending meetings, and submitting reports until released from the probation period by Board staff.
- Pursuant to Ark. Code Ann. §17-87-309, failure to comply with this Order may result in additional disciplinary action on the Respondent's licensure and/or privilege including, but not limited to, additional probation, suspension, or revocation of licensure and/or privilege to practice nursing in this state.

Brought by Ramonda Housh and seconded by Melanie Garner.
PASSED

There being no further business, the meeting adjourned at 6:00 pm.

Lance Lindow, President

Mindy Darner, Recording Secretary

5-11-2022

Date Approved