STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
Fax: (916) 574-7796 or (916) 574-8629 | www.rn.ca.gov

BOARD OF REGISTERED NURSING

CASE NO: 4002019XXXXX
DATE: 11/27/19
FINAL REPORT

SUBJECT:

Name:	**JONES, ANNIE**
Aliases:	None
Address of Record:	Unknown
Residence Telephone:	None
Mobile Telephone:	Unknown
Email Address:	unknown
Description:	Female, Height: 5'10", Weight: 150 pounds Hair: Blond, Eyes: Blue
Date of Birth:	XXXXXXX
CA Driver's License:	XXXXXXXX
Occupation:	Registered Nurse (RN)
Professional License:	CA RN License No. XXXXX Issued: 11/11/2001; Expires: 01/01/2021
Business Address:	Toll House Hospital 23456 Cupcake Way Sacramento, CA 91355
Business Telephone:	(916) 123-4567

COMPLAINT SUMMARY:

Incident One (1): 03/26/18

Allegation: Annie Jones (Jones), RN, is alleged to have done the following action on this date:

- Failed to obtain a signed blood transfusion consent form from Patient 1, Jeffrey Stone an (Stone) prior to administering a blood transfusion
- Documented in Stone's medical records having verified a signed blood transfusion consent form prior to administering a blood transfusion

Incident Two (2): 03/28/18

Allegation: Jones is alleged to have done the following action on this date:

- Failed to administer 1000mg of Dilantin to Patient 2, Betty Henderson (Henderson)
- Falsely documented in Henderson's medical record that the 1000mg of Dilantin was administered

Date Complaint Received: 08/30/18

CHARGES

Business and Professions Code Section 2761 (a): Unprofessional conduct.

Business and Professions Code Section 2761(a)(1): Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

California Code of Regulations, Title 16, Section 1442: Gross Negligence: Includes an extreme departure from the standard of care, which under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required by or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

California Code of Regulations, Title 16, Section 1443: Incompetence: Includes the lack of possession of or the failure to exercise that degree of learning, skill, care

and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

California Code of Regulations, Title 16, Section 1443.5(3): Standards of Competence - A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows; Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

Business and Professions Code Section 2725 (b)(2): Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

SYNOPSIS OF INVESTIGATION:

Jones is currently on BRN probation and is employed at Toll House. Jones's probation is from 05/12/2017 until 05/12/2020. Jones was accused of falsifying a physician order. During a quarterly review, multiple incidents were discovered and reported to BRN probation by Jennifer Bean (Bean). Probation referred the complaints for further investigation.

Records were received from:

- Bean, Toll House, Service Line Director
- Mary Clark (Mary), Toll House, Clinical Nurse Manager
- Kevin Combs (Combs), PC, Attorney for Jones
- Jones

Interviews were conducted with:

- Bean
- Jaimee Timber (Timber), RN
- Julie Moore (Moore), RN
- Barbara Button (Button), RN
- Jones

Incident One (1):

Date of Incident: 03/26/18

Allegation: Jones administered a blood transfusion and failed to obtain a signed consent form from Stone. Stone received his first blood transfusion on 03/26/18 and Jones documented she verified the blood transfusion consent form was signed by Stone and in his chart.

Complainant Bean stated: Jones failed to obtain the blood transfusion consent form prior to Stone's transfusion on 03/26/18 due to the fact that it was not available in Stone's chart.

Witness Timber stated: Timber stated she was asked by Jones to co-sign the blood transfusion process. Timber emphasized Toll House's Policy on Blood Transfusion Guideline 1036-post cap v4 10-20-15 **(Attachment 17 A),** states the requirement for a **verbal verification** of items on the checklist, including the presence of a signed patient consent form for the blood transfusion. Timber stated she did not visually verify the presence of the consent form because she took Jones's word for it and trusted the consent form was signed and available. Timber added the policy has changed since the incident and a visual verification of the items on the checklist including a signed consent form is required.

Witness Button Stated: Button was caring for Stone on the day after the incident, 03/27/18. Button was not able to locate the blood transfusion consent form signed by Stone as she was getting ready to transfuse Stone's second blood transfusion. Due to the missing blood transfusion consent form she had Stone sign a consent form prior to transfusing blood on 03/27/18.

Jones's response in the interview: Jones explained she and Timber both verified the presence of a signed blood transfusion consent form prior to Stone's first blood transfusion on 03/26/18. She claimed the hard copy of the blood transfusion consent form was misplaced.

Incident Two (2):

Date of Incident: 03/28/18

Allegation: Jones documented administering a one-time dose of 1000 mg of Dilantin to Henderson on 03/28/19. The bag of Dilantin with Henderson's name on it was discovered the next day by Henderson's RN, Moore.

Complainant Bean stated: Jones did not administer the 1000 mg of Dilantin because the full bag was discovered the day after Jones documented administration of it. Bean verified with the pharmacy as detailed in the pharmacy correspondence dated 03/29/18 **(Attachment 17D)** indicating only 1 bag of 1000 mg of Dilantin was prepared for Henderson. Furthermore, due to the abnormally low levels of Dilantin in Henderson's blood work on 03/29/19 as detailed in Henderson's medical records **(Attachment 9)** Bean concluded the medication was not administered as documented by Jones.

Witness Moore stated: Moore explained she reviewed Henderson's lab report from blood drawn early morning of 03/29/18 and noticed the Dilantin level was very low. She reviewed Henderson's medical record and noticed a big bolus of Dilantin was ordered by the Neurologist and if the medication was administered as documented by Jones then the Dilantin levels should be within the therapeutic range.

Jones's response in the interview: Jones acknowledged she probably became distracted by the doctor who interrupted her as she was in Henderson's room about to administer the Dilantin. Jones recalled placing the medication in the computer drawer as she exited Henderson's room to speak to the doctor at the nurse's station. She believed she already administered the Dilantin upon returning to Henderson's room and forgot all about the medication. Jones stated, "I take full responsibility" for the incident, and stated she has taken numerous voluntary courses to refresh her RN skills after the incident.

This investigation is referred to the Board of Registered Nursing (BRN) for review and appropriate action.

DEFINITIONS:

Dilantin (Phenytoin): Dilantin (Phenytoin) is an anti-epileptic drug, also called an anticonvulsant. It works by slowing down impulses in the brain that cause seizures. Dilantin is used to control seizures.
https://www.drugs.com/dilantin.html

NARRATIVE OF INVESTIGATION

On 08/30/18, the BRN received a complaint regarding Jones **(Attachment 1)**.

The complaint included the following documents:

- Employee Warning/Termination Notice dated 04/10/18
- Work Performance Evaluation dated 04/10/18
- BRN Job Approval Letter for Jones dated 05/12/17
- Jones's signed Confidential Release Form dated 04/23/17
- Jones's Data Report Form
- Jones's Resume

On 11/27/18, Investigator X, BRN Special Investigator, was assigned to investigate the complaint.

On 03/27/19, I emailed Bean a letter **(Attachment 2)** requesting she contact me to discuss the complaint she filed.

On 03/28/19, I received an email from Bean, and we agreed on a date and time to discuss the complaint.

On 03/29/19, I received a telephone call from Bean and we briefly reviewed her complaint regarding Jones.

Later the same date, I emailed a Facility Request letter dated 03/29/19, a Declaration of Custodian of Records (DCOR), and Jones's signed Confidential Release form **(Attachment 3)** to Bean.

On 06/24/19, I sent an email to Bean inquiring about the status of the requested documents originally requested on 03/29/19.

On 07/10/19, I received an email from Bean apologizing about the delay and informing me the requested documents will be ready by 07/19/19.

On 07/22/19, I received an email from Mary informing me she had the redacted medical records on compact disc (CD) and wanted to schedule a date for me to pick up documents and interview the witnesses. We agreed on a date and time.

On 07/29/19, I picked up the following documents and a DCOR signed and dated 07/29/19 **(Attachment 4)**:

- 2016-2019 Performance Assessments (PA) for Jones **(Attachment 4A)**
- Education transcript for Jones **(Attachment 4B)**
- Toll House Policies relating to the incidents including **(Attachment 4C)**:
    1. Medication Administration, Preparation, Control, Distribution, and Documentation, Date Created: 11/01/1995
    2. Cause for Disciplinary Action, Date Created: 02/01/1995
    3. Blood Transfusion Guidelines, Approved Date:05/21/2018
- Jones's signed job description **(Attachment 4D)**
- Jones's warning/termination notice for 03/28/18 incident **(Attachment 4E)**
- Nursing Assignment Sheets for both incidents **(Attachment 4F)**
- CD with redacted medical records for Patient 1 involved in incident dated 03/26/18 **(Attachment 4G)**
- CD with redacted medical records for Patient 2 involved in incident dated 03/28/18 **(Attachment 4H)**

Later the same date and visit, I interviewed Timber, Moore, and Button.

On 08/05/19, I discovered the medical records for Patient 1 and Patient 2 were not redacted as requested. I sealed the medical records for Patient 1**(Attachment 5)** and Patient 2 **(Attachment 5A)**.

Later the same date, I conducted a skip trace search on Lexis-Nexis for Patient 1, Jeffrey Stone (Stone). I discovered Stone was deceased and obtained the contact

information for his next of kin based on age and a shared residence, Sharon Stone (Sharon). I left a voicemail message for Sharon requesting a return call.

Later the same date, I conducted a skip trace search on Lexis-Nexis for Patient 2, Betty Henderson (Henderson). I left a voicemail message for Henderson requesting a return call.

On 08/09/19, I sent an email to Mary inquiring who the subpoenas need to be directed too. Mary replied to my email and provided the requested information.

On 08/12/19, BRN Chief, Complaint Intake and Investigations, signed a subpoena commanding Toll House to provide me with complete unredacted medical records for the time period of 03/23/18 through 04/07/18 for Stone **(Attachment 6)**. On the same date, BRN Office Technician (OT), served the above-noted subpoena to Toll House and a Notice to Consumer to Sharon via certified mail **(Attachment 6A)**.

Later the same date, the Chief signed a subpoena commanding Toll House to provide me with complete unredacted medical records for the time period of 03/23/18 through 04/14/18 for Henderson **(Attachment 7)**. On the same date, the OT served the above-noted subpoena to Toll House and a Notice to Consumer to Henderson via certified mail **(Attachment 7A)**.

On 08/16/19, I received four (4) Domestic Return Receipts from the United States Postal Service (USPS) indicating receipt of the subpoenas by Toll House and receipt of the Notices to Consumer by Sharon and Stone **(Attachment 7B)**.
On the same date, I also received an objection letter from Sharon for the release of Stone's medical records **(Attachment 8)**.

On 08/19/19, I spoke to Sharon via telephone and she voiced objection to the release of her late husband's (Stone's) medical record because she does not know how her husband would feel about it.

On 09/04/19, I received a DCOR dated 08/28/19 and a CD of Henderson's electronic medical records* **(Attachment 9). The password for the electronic medical records is:1XXXXX**

On 09/13/19, I mailed and emailed a Subject Letter, a Notice to Licensee, and a Licensee Information Update (Update) to Jones **(Attachment 10)**. Within the letter an interview request date, time, and location were detailed. The email was routed back as "undeliverable."

On 09/26/19, I left a voicemail message for Jones requesting a return call to confirm the upcoming interview date and time.

Later the same date, I received a Letter of Representation **(Attachment 11)** and an 800(c) request **(Attachment 11A)** from Combs.

On 09/27/19, the subpoena to obtain Stone's medical records was enforced by the Deputy Attorney General's Office and Sharon signed an Authorization for Release of Medical Information **(Attachment 12)**.

On 09/29/19, I emailed an 800(c) response letter to Combs **(Attachment 13)**.

On 10/03/19, I emailed Bean and Mary a second Facility Request, Stone's signed Release, and a DCOR **(Attachment 14)**.

On 10/11/19, I received Stone's medical records from ABC Health. The attached DCOR was blank **(Attachment 15)**.

On 10/22/19, I emailed an interview confirmation letter to Combs **(Attachment 16)**.

On 10/28/19, I received a telephone call from Combs's office asking to reschedule the interview originally scheduled for 10/30/19.

On 10/30/19, I emailed a rescheduled interview confirmation letter to Combs **(Attachment 16A)**.

On 11/06/19, I picked up the following documents along with a DCOR dated 11/06/19 **(Attachment 17)** from Mary:

- Blood Transfusion Guidelines 1036-post CAP survey, Date Approved 10/23/2015 **(Attachment 17A)**
- Informed Consent Policy, Date Approved 08/03/2015 **(Attachment 17B)**
- 2014-2015 PA's for Jones **(Attachment 17C)**
- Pharmacy correspondence 3/29/18 and two copies of photographs of Dilantin IV bag related to Incident 2 **(Attachment 17D)**
- DCOR dated 10/14/19 and Stone's medical records **(Attachment 17E)**

On 11/07/19, I interviewed Jones.

INTERVIEW: JAMIEE TIMBER, RN- WITNESS 07/29/19 1115 HRS

I met with Timber at Toll House. I identified Timber by her hospital badge. Timber is a licensed RN. Timber's CA RN license number is 12345, which was issued on 01/01/01 and expires on 10/31/20.

The following is a summary of Timber's statement in response to my questioning.

Timber has worked at Toll House's DOU since January 2011. She currently works as a charge nurse during the day shift from 7 am-7pm. Timber explained the Definitive Observation Unit (DOU) is less critical than the Intensive Care Unit (ICU).

I asked Timber to recall a blood transfusion incident that occurred on 03/26/18 involving her colleague, Jones. She stated she recalled there was a missing blood

transfusion consent form in the chart of Patient 1 when Jones asked her to co-sign a blood transfusion administration on the date in question. Timber explained it is hospital policy to have two RN's present during the blood transfusion administration to witness and verify the doctor's order for the transfusion, patient consent, and blood product transfused.

Timber explained the blood is usually brought to the patient's room by a Patient Care Assistant (PCA). Jones already had the blood in the room of Patient 1 when she asked Timber to assist and co-sign the blood. Timber said the first step is to scan the patient's identification (ID) wristband and then the patient's blood bank wristband to ensure patient has been typed and crossed and the blood is compatible. Next the blood product is scanned in multiple places and has a barcode for the blood type and expiration date among other barcodes. Timber stated the RN talks with the patient and asks if they're aware of the blood transfusion ordered by their doctor and a pamphlet is given to the patient the first time a blood transfusion is received.

I asked Timber about the patient's consent. She stated the informed consent is discussed between the doctor and the patient and both sign it. The hard copy of the signed consent form is placed in the patient's chart.

Timber explained that a verbal checklist was exchanged with Jones while in Patient 1's room. Timber asked Jones if there's a doctor's order for the transfusion and Jones replied yes. Timber then asked Jones if the patient consent form is signed and in the chart of Patient 1 and Jones replied yes. According to Timber the co-signing RN does not physically or visually verify that the doctor's order and the consent form are completed they just get the primary RN's verbal acknowledgement there is a doctor's order for the transfusion and the patient has signed the consent and the hard copy is in the patient's chart. Timber added the policy only states that a verbal acknowledgement is required but since the incident under investigation occurred all RN's must visually verify that the doctor's order and the signed consent is available.

Timber said once she verified the verbal checklist, she scanned her badge and entered a personal identification number (pin) into Patient 1's electronic record. She added the blood transfusion cannot proceed without the co-signing nurse's verification. Once the verification was completed, she left the patient's room.

According to Timber the primary RN stays in the patient's room for the first fifteen (15) minutes of the blood transfusion to monitor the patient. The blood transfusion consent is signed the first time the patient receives a blood transfusion and is valid for thirty (30) days. Timber added each time a transfusion is given the RN needs to verify the consent form is signed and in the patient's chart.

I asked Timber if she was disciplined for this incident and she stated her supervisor talked to her about the incident and the necessity to visually verify consent forms

was discussed at safety huddles following the incident on 03/26/18. Timber also stated the hospital's blood transfusion policy was changed after this incident.

In closing Timber said, "It is too bad Tracy (Jones) has to go through this, she is a good nurse."

End of Interview

INTERVIEW: JULIE MOORE, RN- WITNESS 07/29/19 1215 HRS

I met with Moore at Toll House. I identified Moore by her hospital badge. Moore is a licensed RN. Moore's CA RN license number is 56789, which was issued on 01/01/01 and expires on 09/30/21.

The following is a summary of Moore's statement in response to my questioning.

Moore has worked at Toll House since 2004. She currently works as a staff RN in the DOU during the day shift from 7 am-7pm.

I asked Moore to recall the incident which occurred on 03/28/18 involving Jones and Patient 2. Moore recalled Jones was assigned to care for Patient 2 during the day shift of 7am to 7pm on the date in question. Moore was assigned to care for Patient 2 the following day, 03/29/18, also during the day shift of 7am-7pm.

Moore explained at the beginning of her shift she reviewed Patient 2's lab report from blood drawn earlier that morning and noticed the Dilantin level was very low. She reviewed Patient 2's medical record and noticed a big bolus of Dilantin was ordered by the Neurologist and if the medication was administered the Dilantin levels should be within the therapeutic range.

Moore doesn't recall where exactly she found the bolus bag of Dilantin with Patient 2's name on it. She found it that morning possibly in the refrigerator or at the work station. Moore checked to see if the bag of Dilantin was only scanned but not administered. Upon verifying the medical record of Patient 2, Moore discovered the 1000 mg of Dilantin was recorded as administered on 03/28/18 by Jones.

Moore called the pharmacy to ask if a duplicate bag of 1000mg of Dilantin was prepared for Patient 2, but the pharmacy verified it was a one-time dose. Moore reported the incident to her charge nurse, Debbie St. George and they both reviewed the medical record of Patient 2 again. Moore does not remember if Patient 2 was having seizures during the morning of her shift but recalls Patient 2 was lethargic.

Moore informed the doctor about the incident and filled out an incident report. She said that was the last of her involvement with the incident in question and it has not been discussed since.

End of Interview

INTERVIEW: BARBARA BUTTON, RN- WITNESS 07/29/19 1300 HRS

I met with Button at Toll House. I identified Button by her hospital badge. Button is a licensed RN. Button's CA RN license number is 1212121, which was issued on 01/01/01 and expires on 05/30/21.

The following is a summary of Button's statement in response to my questioning.

Button has worked at Toll House since 2015. She currently works as a staff RN in the DOU during the day shift from 7 am-7pm.

I asked Button to recall a blood transfusion incident that occurred on 03/26/18 involving her colleague, Jones.

Button recalled she worked the day shift on 03/27/18 and was assigned to care for Patient 1. Patient 1 had orders to transfuse blood and upon verifying the medical records Button knew Patient 1 received a blood transfusion the previous day on 03/26/19 administered by Jones. Button checked for the signed blood transfusion consent form in the chart of Patient 1 and discovered the hard copy was not in the chart.

Since the consent form was missing, Button obtained a signed blood transfusion consent form from Patient 1 on 03/27/19 and asked if the doctor had discussed the necessities and risks of a blood transfusion with Patient 1. Patient 1 consented and per procedure Button gave Patient 1 an informational pamphlet on blood transfusions. Button then transfused blood as ordered.

Button stated she does not recall who she reported the incident to and does not remember if the missing consent form was documented in the medical records of Patient 1.

End of Interview

INTERVIEW: ANNIE JONES, RN- SUBJECT 11/07/19 1100 HRS

I met with Jones at the Big City County Environmental Health Office located at 12340 Big Sky Street, Happy City. I identified Jones by her California Driver's License (CDL). Also present during the interview was Jones's attorney, Kevin D. Combs. I identified Combs by his CDL.

The following is a summary of Jones's statement in response to my questioning.

Jones provided a copy of her current resume **(Attachment 18)** and a signed Update **(Attachment 19)**.

I asked Jones if she has any prior disciplinary action against her by the BRN. She replied she is currently on BRN probation due to a falsified Physical Therapy (PT) order accusation in 2013. Jones stated her probation ends May 2020. Jones is not currently involved in any lawsuits and she denies ever having been arrested.

Jones has worked at Toll House since January 2014 through present in the DOU. She works the day shift from 7 am to 7 pm. She stated she works with a variety of different patients and the patient to RN ratio is 3 to 1.

I asked Jones to recall the incident under investigation which occurred on 03/26/18 involving Patient 1, Stone. Jones stated she does not recall Stone but does recall receiving a telephone call the day following the incident from Sara Amstel (Amstel), RN asking where Stone's blood transfusion consent form is. Jones told Amstel the consent form must be in Stone's chart or in the bin to be scanned into Stone's electronic medical record.

I asked Jones to explain the blood transfusion procedure at Toll House. Jones explained a patient must have a physician's order for a blood transfusion and the physician is responsible to obtain the patient's informed consent. Once a patient's informed consent is obtained by the physician it is usually detailed in the physician's progress note within the patient's medical record. RN's need to verify if consent has been obtained from the patient or obtain a signed consent prior to the blood transfusion.

According to Jones the blood transfusion process entails the physician educating the patient on the blood, a blood release form is taken to the blood bank by a nurse's aide, the aide brings the blood to the RN. The next steps in the process involve a second RN verifying and co-signing and this process is done on the computer at the patient's bedside. Both RN's verify there is a physician's order for the blood transfusion and the signed patient consent form is in the patient's chart. Jones explained without these steps the blood transfusion process cannot proceed. The co-signing RN helps scan the patient's wristband and patient's blood bank wristband. Finally, the blood product bar codes are scanned

I asked Jones who verified the blood consent form was available in Stone's chart and she replied both she and her co-signing RN, Timber physically verified the hard copy of the consent form was in Stone's chart.

Jones speculated the hard copy of Stone's consent form could have been misplaced or misfiled. She continued to explain there was a similar incident at the hospital the other day where a blood consent form was missing and the charge nurse was overheard by Jones to say, "They lose them all the time."

I asked Jones if she was disciplined for the incident and she replied she was not disciplined and aside from the phone call she received from Amstel, she has not heard anything about the incident until my investigation.

I asked Jones to recall the second incident under investigation which occurred on 03/28/18 involving Patient 2, Henderson. I explained it was alleged that she did not administer the 1000mg of Dilantin to Henderson as documented in Henderson's medical records.

I informed Jones that the complete electronic copy of Henderson's medical record was available for her to review on my State issued laptop.

Jones stated she did not recall Henderson specifically but does recall the incident because she received a phone call from Bean while on vacation. Jones said Bean called her the day after the incident to inform her Henderson's bag of 1000mg Dilantin was found in the medication room and not administered.

Jones recalled obtaining the bag of Dilantin from Pyxis and taking it into Henderson's room where she scanned Henderson's wristband and the medication. While she was scanning the medication Jones recalled Dr. Singh the trauma surgeon interrupted her scanning process and came into Henderson's room. Dr. Singh wanted to go over Henderson's chart and the plan.

Prior to walking over to the nurse's station with Dr. Singh, Jones believes she either hung the bag of Dilantin on the IV pole or placed the medication into the computer station drawer and locked it with a key.

Jones said she returned to Henderson's room after about ten (10) minutes and believed she had already administered the Dilantin. Jones added, "I think that's what happened to the best of my knowledge."

I asked Jones to refer to page 338 of Henderson's medical records **(Attachment 9)** where it indicates the Dilantin 1000mg was documented as administered by Jones on 03/28/18 at 1356. Jones acknowledged the documentation. Next, we referred to page 167 of the records at Dr. Donald Wright' Progress note form 03/29/19 at 1403 where the doctor noted: "According to nursing she seizure this morning described as nystagmus and stating to the left." Jones acknowledged the documentation. Next, we referred to page 418 of the records detailing the lab results for Henderson's Phenytoin (Dilantin) levels measure on 03/29/18 to register at "Abnormal Low." Jones acknowledged the documentation.

Next, we referred to the email and photograph of the bag of Dilantin from the pharmacist **(Attachment 17D)** verifying that only one bag of Phenytoin (Dilantin 1000mg) was formulated for Henderson and based on the low Phenytoin levels in Henderson's blood it is suggested the Dilantin was scanned but not administered. Jones acknowledged the documentation.

Jones added, **"I take full responsibility" for the incident**, and stated she has taken numerous voluntary courses to refresh her RN skills after the incident.

I asked Jones if she was disciplined for the incident involving the Dilantin and she stated she was placed on a ninety (90) day probation by her supervisor without any restrictions. During the 90 days she met periodically with her supervisor to gauge her progress. She has successfully completed her 90-day probation.

In closing, Jones provided a binder of documents **(Attachment 20)** for the BRN's consideration and review. Among the documents were: Performance Evaluations, Recognition of Professional Performance, Education and Training Certificates, and Letters of Support.

DOCUMENT REVIEW:

Incident 1 (03/26/18):

In reviewing Stone's (Patient 1's) medical record **(Attachment 17E),** I noted the following:

- The Informed Consent for Blood Transfusion form was signed on **03/27/18** by Stone and Button.
- On page 9 of the Blood Bank record it is stated Stone received a blood transfusion on **03/26/18 and 03/27/18**.
- On page 3 of the BBK Transfusions record it is stated Jones verified and documented on 03/26/18 1349 **Pt Consent Signed**

In reviewing Toll House's Policy on Blood Transfusion Guideline 1036-post cap v4 10-20-15 **(Attachment 17A)** I noted the following:

- On page 5 Section VI Item 2 states "Two licensed personnel **verify** all items on Checklist by explicit **verbal** acknowledgement:
  a. MD order
  b. Patient consent signed

Incident 2 (03/28/18):

In reviewing Henderson's (Patient 2's) medical record **(Attachment 9)**, I noted the following:

- On pages 94-96 of the OE Order Summary Report, Jones acknowledged the one-time order of one bag of 1000 mg Dilantin on 03/28/18
- On page 167 Henderson's Labs indicate a value of 0.8 ug/mL Dilantin level as measured in the blood drawn 03/29/18 0454

- On page 338 of the Medication Discharge Summary it is documented Jones administered the 1000 mg of Dilantin on 03/28/18 at 1356
- On page 418 of the Special Chemistry Labs indicate Phenytoin (Dilantin) levels in Henderson's blood drawn 3/29/18 1209 was 8.9 ug/mL L **(Abnormal Low)** and at 03/29/18 0454 0.8 ug/mL L **(Abnormal Low) ***expected Phenytoin levels range 10.0-20.0 ug/mL**

In reviewing the Pharmacy correspondence dated 3/29/18 and the photographs of the Dilantin IV bag with Henderson's name on it **(Attachment 17 D),** I noted the following:

- the pharmacy confirmed only one bag of 1000 mg of Dilantin was prepared for Henderson

ATTACHMENTS:

1. Copy of the Bean's complaint to the BRN.

2. Letter to Bean dated 03/27/19

3. Facility Request Letter dated 03/29/19 with attachments

4. DCOR dated 07/29/19

A. 2016-2019 Performance Assessments (PA) for Jones

B. Education transcript for Jones

C. Toll House Policies relating to the incidents including:

- Medication Administration, Preparation, Control, Distribution, and Documentation, Date Created: 11/01/1995
- Cause for Disciplinary Action, Date Created: 02/01/1995
- Blood Transfusion Guidelines, Approved Date:05/21/2018

D. Jones's job description

E. Jones's warning/termination notice dated 3/28/18

F. Nursing Assignment Sheets for both incidents

G. CD with redacted medical records for Patient 1 involved in incident dated 3/26/18

H. CD with redacted medical records for Patient 2 involved in incident dated 3/28/18

5. Sealed medical records for Patient 1

A. Sealed medical records for Patient 2

6. Subpoena to Toll House for Stone's medical records

A. Proof of Service and Notice to Consumer for Sharon

7. Subpoena to Toll House for Henderson's medical records

A. Proof of Service and Notice to Consumer for Henderson
B. USPS Domestic Return Receipts

8. Sharon's objection to the subpoena letter

9. CD of DCOR signed 08/28/19 and Henderson's electronic medical records

10. Subject letter to Jones with attachments

11. LOR from Combs

A. 800(c) request letter

12. Stone's signed Release form Sharon

13. 800(c) response letter

14. Facility Request letter dated 10/03/19 and Stone's signed Released

15. Copy of Stone's medical records form Ciox Health with blank DCOR

16. Interview confirmation letter to Combs

- **A.** Rescheduled interview confirmation letter to Combs

17. DCOR dated 11/06/19

- **A.** Blood Transfusion Guidelines 1036-post CAP survey, Date Approved 10/23/2015
- **B.** Informed Consent Policy, Date Approved 08/03/2015
- **C.** 2014-2015 PA's for Jones
- **D.** Pharmacy correspondence 3/29/18 and two copies of photographs of Dilantin IV bag related to Incident 2
- **E.** DCOR dated 10/14/19 and Stone's medical records

18. Jones's resume

19. Signed Update

20. Binder from Jones with documents