

LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS  
131 AIRLINE DRIVE, SUITE 301  
METAIRIE, LOUISIANA 70001-6266  
(504) 838-5791  
FAX (504) 838-5279  
www.lsbpne.com

March 13, 2015

Shamika Taylor  
PO Box 2334  
Patterson, LA 70392

Dear Ms. Taylor:

Enclosed you will find your board order with the stipulations set forth which you **must follow** throughout your suspension and/or probation period.

Please read the entire order **completely and carefully**. Failure to follow **all** stipulations set forth may result in further disciplinary action being taken against your practical nursing license, which may include additional fines, an extended probation period, suspension, revocation and/or denial of licensure.

You may also go to the board's website at [www.lsbpne.com](http://www.lsbpne.com) at any time to review the Administrative Code pertaining to practical nurses, including the Rules and Adjudication, License Suspension and Revocation Proceedings, §306. This information was also included with your formal complaint.

If you have any questions or concerns you should submit them in writing to the board office. Please include your current address and telephone number with your request.

LOUISIANA STATE BOARD OF  
PRACTICAL NURSE EXAMINERS

*M Lynn Ansardi RN*

M. Lynn Ansardi, RN  
Executive Director

MLA/kp

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In the matter of:

**Shamika Taylor**  
**License # 20100789**

This cause having come to be heard at a formal hearing conducted at the board office on **July 25, 2014 at 1:00 p.m.** and **August 29, 2014 at 11:00 a.m.** upon the complaint filed in this matter.

1. The respondent did appear at the scheduled hearing and did give sworn testimony.
2. The following witnesses were called to give sworn testimony on the board's behalf:
  - Kelsea Carter, LPN
  - Chris Delaune, RN
  - Mary Beth Pillaro (via telephone)
  - Michael Brown, LPN
  - Danielle Coleman, RN

\*The hearing officer found the witnesses to be credible.

3. Exhibits A1-L1 were admitted into evidence. The hearing officer reviewed and considered all exhibits.
4. The hearing officer fully reviewed and considered the transcript of the hearing as prepared and certified by the court reporter, Dawn H. Hymel, CCR, who was present and recorded the hearing.

The hearing officer, having reviewed all evidence and testimony, and being fully advised in the premises, makes the following findings of fact and conclusions of law based on the entire record:

**FINDINGS OF FACT**

1. The respondent was issued a license to practice practical nursing in the state of Louisiana on June 24, 2010.
2. While employed as a licensed practical nurse with Chateau Terrebonne Healthcare, the respondent administered the incorrect medications to a patient in her care.

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On October 25, 2013, at 8:00 p.m. the respondent entered the room of C.B. and J. R. with two soufflé cups of medications. Mr. J. R. got up to get some water to take his medications. The respondent handed C. B. a soufflé cup of medications which he immediately took. The respondent then handed J. R. the other cup of medications which he noted and responded were not his medications. The respondent then handed C. B. the soufflé cup and he took those medications as well. The respondent then went to the medication cart and dispensed another set of medications and administered them to J. R. (Refer to Exhibits B1-B28, C2-C15)

The respondent administered the following medications in error to C. B.

- Xanax
- Remeron
- Seroquel
- Neurontin
- Mucus Relief
- Carafate
- Prilosec
- Requip
- Morphine Sulfate

The respondent after being notified of her error then administered C. B. his routine medications of

- Pravastatin Sodium
- Omeprazole
- Clonazepam

3. The respondent failed to notify the doctor, the family, the supervisor or the oncoming nurse of the medication error. The respondent also failed to document the error in the nursing notes, and failed to complete an I&A form or medication error report.
4. At 7:00 a.m. the oncoming nurse found C. B. on the floor lying on his right side. The nurse performed an assessment and assisted the patient back to bed. The patient was noted to be drowsy throughout the shift but would respond to simple commands. At noon, J. R. informed the registered nurse supervisor of the medication error. An order was given to monitor the resident. At 7:45 p.m. the resident was found lying in bed with eyes closed, unable to arouse. Sternal rub and shaking were unsuccessful in arousing the patient. The patient's finger tips were cyanotic and his blood sugar results were 270. His oxygen saturation was 58. Respiratory was called to the room due to the resident appearing

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lethargic. The doctor was notified and ordered narcan 1 amp every 2 hours until awake. Narcan was not available at the facility so the patient was sent to Terrebonne General Emergency Room. (Refer to Exhibits C11-C16)

5. Upon discharge the patient's diagnosis included narcotic toxicity.(Refer to Exhibit E5)
6. The respondent stated to the facility that the only medications administered in error to patient C. B. were Zofran, Vistaril and Prilosec. She denies any narcotics were administered in error.
7. However, according to the narcotic administration records for J. R. it appears the respondent removed narcotics twice and tried to cover her mistake by falsifying the narcotic records for Xanax and Morphine.
8. While employed as a licensed practical nurse with Patterson Healthcare from June 3, 2010 to August 8, 2010 the respondent was counseled for the following:
  - 7/26/10 Failing to correct a narcotic count-Upon shift change it was noted Klonopin was missing for a resident. The respondent corrected the count without completing an investigation.
  - 8/3/10 Not following the MAR-The respondent failed to administer resident A. N. medications, failed to follow-up with the pharmacy and failed to notify the Director of Nursing that the medications were not in the facility.
  - 8/4/10 The respondent failed to re-admit a patient to the facility
  - 8/12/10 The respondent documented administration of eye drops to a resident; however, the eye drops were found in the medication cart, unopened. The medications were received in the facility on August 4, 2010.
  - 8/12/10 The respondent failed to administer resident Hilliard his Ativan on three previous days.
  - 8/17/10 The respondent failed to notify the physician of swelling to the right arm of a dialysis patient with a port site. The patient was admitted to the emergency room with an infection to the site.

The respondent was terminated from the facility due to failure to follow procedure and failure to notify the physician related to patient care.

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After listening to sworn testimony and reviewing all records, the hearing officer finds that on 10/25/13, the respondent did administer the incorrect medications to the patient. The respondent admitted to administering Zofran, Vistaril and Prilosec in error. However, she denied administering any narcotics to the patient in error. The patient's roommate is on the above medications as well as Morphine. On 10/26/13, the patient fell and sustained skin tears to the left elbow and knee. Later that evening, the patient began to show signs of respiratory distress and lethargy. The patient was admitted to the critical care unit at Terrebonne General Medical Center. The patient was found to have narcotic toxicity, which is why he was exhibiting signs of respiratory depression and lethargy. He was placed on a Narcan drip. It was proven that the respondent did not report the medication error, nor did she document the error.

The hearing officer finds that the respondent knowingly failed to protect the patient.

The board has jurisdiction over the parties hereto and the subject matter hereof.

**CONCLUSIONS OF LAW**

**Based on the facts set forth in the entire record and outlined herein above, the respondent is in violation of the following:**

1. The Louisiana Revised Statutes of 1950, Title 37, Chapter 11, Part II, Section 969 A. (4);

**(c) is unfit, or incompetent by reason of negligence habit, or other causes;**  
**(f) is guilty of unprofessional conduct;**  
**(g) has violated any provisions of this Part;**

**And 978 A (8) Violate any provisions of this Part and B.**

2. The Louisiana Administrative Code, Title 46, Part XLVII, Subpart 1, Sections § 306 T.

3. **being unfit, or incompetent by reason of negligence, habit or other causes;**  
8. **being guilty of unprofessional conduct;**
- a. **failure to practice practical nursing in accordance with the standards normally expected;**
  - b. **failure to utilize appropriate judgment in administering nursing practice;**
  - c. **failure to exercise technical competence in carrying out nursing care;**
  - g. **improper use of drugs, medical supplies, or patients' records;**
  - i. **falsifying records;**

- j. intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient;
- p. inappropriate, incomplete or improper documentation;
- t. violating any provisions of R.S. 37:961 et seq. (the practical nursing practice act), as amended or aiding or abetting therein.

The matter of Shamika Taylor, license #20100789, on March 13, 2015 came on for final action by the Louisiana State Board of Practical Nurse Examiners.

**NOW THEREFORE, IT IS ORDERED**, that the license of the respondent, Shamika Taylor, license #20100789 be Suspended for no less than One Year with the following stipulations:

1. **Return license to the board office:**
  - A. The respondent shall return his/her current practical nursing license to the board office within ten (10) days of the date of this order.
  - B. The respondent shall not practice nursing during the period that his/her license is suspended.
2. **Obey all laws:**
  - A. The respondent shall obey all laws/rules governing the practice of practical nursing in this state and obey all federal, state, and local laws.
  - B. The respondent shall report to the board within ten (10) days any misdemeanor and/or felony arrest(s) or conviction(s).
3. **Notify board of change of address/telephone number:**
  - A. The respondent shall notify the board in writing within ten (10) days of any change in personal address or telephone number.
4. **Fines/Fees:**
  - A. The respondent is hereby fined \$500.00, payable by cashier's check or money order only, for the violations detailed in the conclusions of law, payable within 90 days from the date this order is executed.

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B. The respondent is hereby assessed a hearing assessment fee of \$1000.00, **payable by cashier's check or money order only**, within **90 days** of the date of this order.

5. **Courses:**

The respondent must take and satisfactorily complete board approved courses in the following areas:

- ETHICS-8 HOURS
- DOCUMENTATION-15 HOURS
- MEDICATION ADMINISTRATION-15 HOURS

Evidence of completion of the course(s) is due in the board office prior to the respondent's request for reinstatement.

6. **Reinstatement requirements:**

- A. All stipulations of the suspension must be successfully fulfilled prior to a request for reinstatement.
- B. The respondent is to submit a written request for reinstatement to the board office.

Upon favorable review of the reinstatement request, the license of the respondent may then be placed on probation for a minimum period of **two (2) years**. During this probationary period the respondent shall follow **stipulations #2 & 3 as stipulated above and the following stipulations as stipulated below:**

1. **License:**

- A. The license of the respondent will be stamped "**PROBATION**".

2. **Fines/Fees:**

- A. The respondent is to submit a \$500.00 annual probation monitoring fee, **payable by cashier's check or money order only**.

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- B. The probation monitoring fee is due within **three (3) months** of receiving a probated license and annually thereafter until the probation is satisfactorily completed.
- C. Failure to pay this fee in the time allotted will result in the immediate suspension of the respondent's practical nursing license.
- D. The respondent must pay any/all fines/fees owed to the board, including a reinstatement fee, if/when applicable. Fines/fees are **payable by cashier's check or money order only**.

3. **Employment:**

- A. The respondent shall provide a copy of the entire board order/consent order including the findings of fact and conclusions of law immediately to any/all current employer(s) and at the time of application to any/all prospective employer(s).
  - i. If the respondent is already employed as an LPN, the respondent and the current employer shall enter into the board's **Employer's Agreement** (form(s) issued by board). The signed form(s) shall be submitted to the board office within **ten (10) days** of the date of the board order/consent order.
  - ii. Upon obtaining new employment as an LPN, the respondent shall enter into the board's **Employer's Agreement** (form(s) issued by board) with the prospective employer. The signed form(s) shall be submitted to the board office within **ten (10) days** of the date of hire.
- B. All current and prospective employers must agree to allow the respondent's direct supervisor to monitor the respondent while on probation as well as timely submission of evaluations.
- C. Probation will run concurrent with employment as an LPN.
- D. The respondent must be employed a minimum of 80 hours per month.

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- E. The probationary period will not commence or progress until and unless the respondent is employed and delivering direct patient care as a licensed practical nurse.
- F. Failure to maintain stable employment may be grounds for termination of probation.
- G. The respondent must practice under the supervision of a nurse (RN or LPN) or physician whose license is unencumbered and must provide direct patient care as follows:
  - i. The respondent must be supervised on a regular and consistent basis by his/her assigned supervisor. The supervisor must observe and work closely enough with the respondent to be able to give an informed evaluation of the respondent. The employer must be willing to allow this supervision and provide opportunities for the same supervisor to evaluate the performance of the respondent.
  - ii. It is the respondent's responsibility to ensure that his/her supervisor submits the evaluation reports quarterly.
    - a. Reports are due on or before the 10<sup>th</sup> day of January, April, July, and October of each year. (Note: these forms will be provided to the employer)
    - b. Only the respondent's direct supervisor may complete the evaluations according to the observations made during the supervision.
- H. The respondent is prohibited from working in temporary staffing, as an agency nurse, for a nursing pool and/or in the home health setting, or in any other similar setting including but not limited to working in a teaching capacity, as a travel nurse and/or on an "as needed" basis - prn.
- I. The respondent shall notify the board in writing within **ten (10) days** of any change in employment. Changes in employment include accepting a new job, as well as resignation, or termination.
- J. Upon obtaining a prescription for controlled/abuse potential substance(s) while holding a probated license, the respondent is responsible for informing his/her employer within **three (3) days** from the date of the prescription(s).

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## Violations

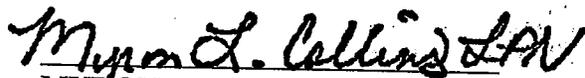
The respondent is hereby notified that failure to comply with any stipulations of this order of the board may result in any or all of the following:

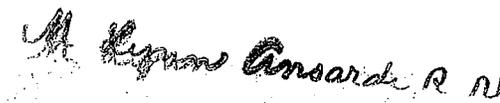
- a) immediate suspension of license, b) indefinite suspension of license, c) ineligibility for annual renewal of license, d) additional fines/penalties up to \$500.00 per occurrence, e) increased probationary period, f) summary suspension and g) revocation.

## Public Records

This order is public record. All disciplinary actions of the board will be reported to all required data banks and agencies as required by law.

Rendered this 13th day of March, 2015 and signed this 13th day of March, 2015 at Metairie, Louisiana.

  
MYRON COLLINS, LPN  
CHAIRMAN OF THE BOARD

  
M. LYNN ANSARDI, RN  
EXECUTIVE DIRECTOR

Mailed this 13th day of March, 2015, by U.S. postal service certified mail return receipt #7014 2120 0003 8719 3004 and regular mail to the following address:

Shamika Taylor  
PO Box 2334  
Patterson, LA 70392