LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS
3421 NORTH CAUSEWAY BOULEVARD, SUITE 505
METAIRIE, LOUISIANA 70002-3715
(504) 838-5791
FAX (504) 838-5279
www.lsbpne.com

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
7001 2510 0009 3556 9905

La Toya Johnson
12013 Roddy Rd. #21
Gonzales, LA 70737

License #220325
D.O.B. 10/28/74

The matter of license #220325 came on for final action by the Louisiana State Board of Practical Nurse Examiners on the 25TH day of June, 2004

FINDINGS OF FACT

That on September 25, 2003 the board received a report from the Department of Health and Hospitals indicating that while the respondent was employed as a licensed practical nurse at Regency Place on September 14, 2003, she was given an order to have a resident x-rayed. She documented that she notified the x-ray company from her desk phone and gave the resident 1000 mg of Tylenol. This documentation was found out of sequence in the nursing notes after the resident had been admitted to the hospital the evening of September 16, 2003. The MAR did not reveal Tylenol being given. When questioned on September 17, 2003 as to why her documentation was out of sequence, the respondent replied , "I don't know, I guess the page was flipped". The x-ray company answering service (Tele - Sec) denies any phone calls being received from this facility on September 15, 2003.

Another LPN was questioned by NFA regarding the presence of documentation on September 15, 2003 when she made her entry on September 16, 2003. The LPN denies any entry being present. The nursing notes page also had 3 holes punched on both sides of the page. The x-ray had been obtained on September 16, 2003 and the resident was sent to the hospital.

That on September 18, 2003 J. Mc Cabe, RN, DON and Barbara Van Lieu, RN, NFA spoke with the respondent who claimed she did notify the x-ray company. When asked why her documentation was out of sequence, the respondent replied, "it was a later entry". She was informed that the documentation did not reflect this and had no comment. B. Van Lieu asked why if the documentation was a late entry, did she not inform them (B. Van Lieu) when questioned on September 17, 2003 about the authenticity and accuracy of the note. The respondent responded, "you didn't ask". The respondent was informed of the seriousness of the matter and she would be suspended pending an investigation. She asked why she was being suspended and B. Van Lieu replied that there were many issues and inconsistencies that must be addressed, including:

1. Failure to follow MD orders.
2. Questionable falsification of documentation.
3. Failure to follow standards of practice of facility policy on narrative documentation and medication administration.

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The respondent replied that there were other nurses involved too and questioned whether they were being suspended. Ms. Mc Cabe replied that every nurse involved was being dealt with by the nursing administration. Ms. Van Lieu informed the respondent that her neglect to the resident was only one part of the problem the other issues had been outlined.

The respondent was informed that she was being suspended immediately and once the nursing administration concluded the investigation, she would be contacted. The respondent verbalized an understanding.

That on October 23, 2003 the board requested a detailed narrative statement regarding the allegations. No response was received.

That on January 12, 2004 the respondent contacted the board office regarding the renewal of her 2004 license. At that time she gave the board a new address and the board re-mailed the request for a narrative statement to the respondent's new address.

That on January 20, 2004 the respondent's license was renewed but to date she has not submitted the requested narrative statement.

A formal hearing was held on June 3, 2004 and the respondent appeared (see in testimony).

CONCLUSIONS OF LAW

Based on the findings, the Board makes the following Conclusion of Law:

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

2. Based on the above findings, the respondent is in violation of the Louisiana Revised Statute, Title 37, Chapter 11 Nurses, Part II Practical Nurses, Section 969 A.(4)(f) is guilty of unprofessional conduct, and the Louisiana Administrative Code, Title 46, Part XLVII. Nurses, Subpart 1, Practical Nurses, Section 306, T.8.a. failure to practice practical nursing in accordance with the standards normally expected, b. failure to utilize appropriate judgement in administering nursing practice, p. inappropriate, incomplete or improper documentation.

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ORDER

NOW THEREFORE, IT IS ORDERED that the respondent, La Toya Johnson, license #220325, be issued a Letter of Reprimand regarding her license.

1. Be required to complete courses in documentation and medical ethics and submit evidence of completion to the Board within 90 days of the Board Order.

2. Be fined $50.00 (fifty dollars) for the violations detailed in the Conclusions of Law .

3. Be assessed a hearing fee of $500.00.

Rendered this 25th day of June, 2004 and signed this 29th day of June, 2004 at Metairie, Louisiana.

ANN LAWS, RN
CHAIRMAN OF THE BOARD

CLAIRE GLAVIANO, RN, BSN, MN
EXECUTIVE DIRECTOR

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In the matter of:

La Toya Johnson
12013 Roddy Rd. #21
Gonzales, LA 70737

License #220325
D.O.B. 10/28/74

LETTER OF REPRIMAND

The Louisiana State Board of Practical Nurse Examiners hereby issues this letter of reprimand against La Toya Johnson, LPN based on the following:

- That the respondent was reported by the Department of Health and Hospitals to the board for not following MD orders, falsification of documentation and failure to follow standards of practice of facility policy on narrative documentation and medication administration.

- That the respondent admitted to the allegations contained in the complaint.

Based on the evidence submitted, the Board has concluded that Ms. Johnson is in violation of the following provisions of Louisiana Revised Statutes, Title 37, Chapter 11. Nurses, Part II. Practical Nurses, Section 969 as defined in the Louisiana Administrative Code, Title 46, Part XLVII. Nurses, Subpart 1, Practical Nurses, Section 306:

- being guilty of unprofessional conduct
- failure to practice practical nursing in accordance with the standards normally expected
- failure to utilize appropriate judgement in administering nursing practice
- inappropriate, incomplete or improper documentation.

This letter of reprimand is considered disciplinary action by the Louisiana State Board of Practical Nurse Examiners and is reportable as such.

Claire Doody Glaviano

Claire Doody Glaviano
Executive Director