

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

July 31, 2015

Theresa Hawkins
P.O. Box 17733
Shreveport, LA 71138

Dear Ms. Hawkins:

Enclosed you will find your board order.

You may also go to the board's website at www.lsbpne.com at any time to review the administrative code pertaining to practical nurses.

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/kg

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In the matter of: Theresa Hawkins
License # 992426
D.O.B. 01/21/1966

This cause having come to be heard upon the complaint filed herein, the evidence and testimony entered before the undersigned hearing officer on September 26, 2014.

1. The respondent was present for the hearing and did give sworn testimony
2. There were four (4) witnesses called by the board to testify at the formal hearing. These witnesses were:
 - Ebony Leftridge, LPN
 - Belinda Wilson, CNA
 - Bernadine Stills, CNA
 - Jacqueline Johnson

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, by endorsement, to practice practical nursing in the state of Louisiana on September 9, 1999.
2. On March 3, 2014, the respondent neglected a patient in her care when she failed to appropriately respond to a change in his condition, while employed by Pierremont Healthcare Center.
3. The respondent was notified at the beginning of her shift on March 3, 2014, that the patient's behavior and appearance were different. (Refer to exhibits D-5 and D-6 and page 11 lines 10-25, page 12 lines 1-25, page 13 lines 1-9, page 59 lines 11-25, page 60 lines 1-17 page 61 lines 3 to 25 and page 62 line 1 of the hearing transcript.)
4. The respondent noted the patient to have increased congestion in his chest and the patient informed the respondent that he was not feeling well. The respondent failed to intervene or provide appropriate nursing care. She failed to perform an assessment on the patient, failed to notify the physician, failed to notify the family and failed to completely document her findings in the nursing notes. (Refer to exhibit C-17, D-13 and page 78 lines 16-25, page 79 lines 1-25, page 80 lines 1-25, page 81 lines 1-25, page 82 lines 1-25 and page 83 line 1 of the hearing transcript.)

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5. At approximately 4:30 p.m., the respondent administered medications to the patient and failed to practice safe nursing by ensuring the patient had swallowed the medications. (Refer to exhibit C-20, D-13, F-2 and page 42 lines 6-17, page 50 lines 10-25, page 51 line 1 of the hearing transcript.)
6. The patient was found in respiratory distress at approximately 6:30 p.m., with oxygen saturation at 80%. The respondent failed to intervene and provide appropriate nursing care. The respondent initially placed the resident on two liters of oxygen per nasal cannula, gradually increasing to five liters over an elapsed period of 52 minutes with minimal improvement noted to the patient's condition. The respondent exhibited poor nursing judgment in that she failed to notify the physician, failed to call for emergency transport, failed to notify the family, and failed to notify the supervisor of the resident's change in condition. (Refer to exhibits C-17 to C-18 and pages 84-100 of the hearing transcript.)
7. The respondent did not call for emergency transport of the patient until instructed to do so by the assistant director of nursing. This was prompted by a complaint from a family member who arrived at the facility out of the concern for the care the patient was receiving by the respondent. (Refer to D-4; pages 17 to 33 and pages 35 to 54 of the hearing transcript.)
8. The respondent could not be located upon arrival of emergency transport, so report was given by the family. The patient was discovered in a critically emergent state with bloody stools covering his back and arms, and a foley catheter in place with cloudy/yellow brown output. The patient exhibited labored breathing on 5 liters of oxygen via nasal cannula. He was tachypneic with gurgling respirations and pulmonary edema. The patient coded at the emergency room and was placed on a ventilator. (Refer to exhibits C-26 to C-45.)
9. During the respondent's employment with Pierremont she was previously counseled for incidents involving failure to use appropriate judgment and provide appropriate care that could have resulted in harm to patients assigned to her care.
 - 3/13/12 The respondent received critical labs on a patient and failed to notify the physician.
 - 6/6/12 The respondent left her medication cart unlocked, left her medication cart parked in the doorway of a resident and was insubordinate to a supervisor.
 - 6/24/13 The respondent failed to properly write a medication dosage on a patient's medication administration record. Instead of re-writing the order, the respondent wrote over the existing order.

JURISDICTION

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;**
 - j. **intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient;**
 - o. **being guilty of moral turpitude;**
 - 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.**

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ORDER

The matter of Theresa Hawkins, license #992426 on July 31, 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, Theresa Hawkins, license #992426 be

REVOKED AND

1. The respondent is hereby fined \$500.00, payable by money order or cashier's check only, for the violations detailed in the conclusions of law, and due within 90 days of the date of this order.
2. A hearing assessment fee of \$500.00, payable by money order or cashier's check only, is to be submitted to the board within 90 days of the date of this order.
3. The respondent shall return his/her current practical nursing license to the board office within three (3) days of the date of this order.

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 31st day of July, 2015 and signed this 31st day of July, 2015 at Metairie, Louisiana.


MYRON COLLINS, LPN
CHAIRMAN OF THE BOARD


M. LYNN ANSARDI, RN
EXECUTIVE DIRECTOR

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Mailed this 31st day of July, 2015, by U.S. postal service certified mail return receipt #7015
0920 0001 4574 9167 and regular mail to the following address:

Theresa Hawkins
P. O. Box 17733
Shreveport, LA 71138