BEFORE THE INDIANA STATE BOARD OF NURSING
CAUSE NO: 2013 NB 007

IN THE MATTER OF THE LICENSE OF)
TINA M. BATCHELOR, L.P.N.)
LICENSE NO: 27054582A)

FINAL ORDER ACCEPTING PROPOSED FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The State of Indiana ("Petitioner"), by the Office of the Attorney General, by Laura E. Wilford Deputy Attorney General, and Tina M. Batchelor, L.P.N. ("Respondent") by Counsel Adam Clay and Matt Black, signed a Proposed Settlement Agreement ("Agreement") which purports to resolve all issues involved in the action by the Petitioner and the Indiana State Board of Nursing ("Board") regarding the Respondent's license, and which Agreement has been submitted to the Board for approval.

The Board after reviewing the Agreement at the April 18, 2013 meeting, held in the Auditorium of the Indiana Government Center South, 302 West Washington Street, Indianapolis, Indiana 46204, now finds it has been entered into fairly and without fraud, duress, or undue influence, and is fair and equitable between the parties. The Board hereby incorporates the Agreement which is attached hereto and incorporated herein as **Exhibit A** and approves and adopts in full the Agreement as a resolution of this matter. The Board approved this Agreement by a vote of 5-0-0. Incorporated into the Agreement was the consensus of both parties to Findings of Fact, Conclusions of Law and Order.

WHEREFORE, the Board hereby accepts and approves the Agreement, settling all matters in this case consistent with the terms of the Agreement between the parties, and Respondent is hereby ORDERED to abide by all the terms of the Agreement.

SO ORDERED, this 26 day of April 2013.

INDIANA STATE BOARD OF NURSING

By: _____

Virgil R. Madden, Executive Director
Indiana Professional Licensing Agency

CERTIFICATE OF SERVICE

I certify that a copy of the "Final Order Accepting Proposed Findings of Fact, Conclusions of Law and Order" has been duly served upon:

Tina M. Batchelor
4827 East 200 North
Milan, Indiana 47031
Service by U.S. Mail

Adam Clay
Black Clay LLC
9333 N. Meridian St., Suite 370
Indianapolis, IN 46260
Service by U.S. Mail

Matt Black
Black Clay LLC
9333 N. Meridian St., Suite 370
Indianapolis, IN 46260
Service by U.S. Mail

Laura E. Wilford
8005 Castleway Drive
Indianapolis, Indiana 46250
Laura.Wilford@atg.in.gov
Service by Email

26 April 13
Date

Lisa Chapman
First/Last Name of Person Mailing

Indiana State Board of Nursing
Indiana Government Center South
402 West Washington St., Room W072
Indianapolis, IN 46204
Phone: 317-234-2043
Fax: 317-233-4236
Email: pla2@pla.in.gov

Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual's electronic mail address.

BEFORE THE INDIANA STATE BOARD OF NURSING
CAUSE NUMBER: 2013 NB 007

IN THE MATTER OF THE LICENSE OF TINA M. BATCHELOR, L.P.N. LICENSE NO: 27054582A (ACTIVE)

PROPOSED SETTLEMENT AGREEMENT

The State of Indiana, by Laura E. Wilford, Deputy Attorney General ("Petitioner") and Tina M. Batchelor, L.P.N. ("Respondent") by counsels Adam Clay and Matt Black hereby execute this Agreement to a disposition of the Complaint filed in this cause pursuant to a Pre-Hearing/Settlement Conference held March 7, 2013 with the Indiana State Board of Nursing member/designee Karen Dolk, R.N. This Agreement is subject to the review and approval of the Indiana State Board of Nursing ("Board") pursuant to Ind. Code ch. 25-1-9 and the Administrative Orders and Procedures Act, Ind. Code ch. 4-21.5-3.

STIPULATED FACTS

1. Respondent is a Licensed Practical Nurse in the State of Indiana having been issued license number 27054582A on October 5, 2004.

2. Respondent holds an active Practical Nurse license in Ohio which she received in March 2011 and which expires August 2014.

3. Respondent's address on file with the Indiana Professional Licensing Agency is 4827 E. CR 200 N., Milan, Indiana 47031.

4. On or around February 3, 2009, Respondent began employment as a nurse at The Waters of Batesville ("Waters") located in Batesville, Indiana.

5. On or around June 28, 2009, Waters issued Respondent a "documented" oral warning due to Respondent's failure to follow department procedures and poor work

Exhibit A

performance. Respondent had failed to initial that she checked the bed and chair alarms for patients at the end of her shift. It was noted that this was a repeated problem.

6. On or around July 21, 2009, Waters issued Respondent a written warning for poor work performance. Respondent had transcribed an order for a blood draw in the wrong resident's treatment administration record.

7. On or around September 21, 2009, Resident A, a sixty-one year-old male, was admitted to Waters at noon with an admitting diagnosis of total replacement of the left knee, congestive heart failure, insulin dependent type 2 diabetes, chronic renal insufficiency, carpal tunnel syndrome, osteoarthritis, and obstructive sleep apnea. Upon Resident A's admission to the facility, Resident A's wife provided the facility with Humulin R U-500 (concentrated) insulin medication that Resident A received from the Veterans Hospital due to his large insulin requirements. Dr. Stephen Glaser, M.D. was Resident A's physician. Humulin R U-100 was the insulin carried by the facility pharmacy.

8. At 8:00 p.m., Respondent transcribed Dr. Glaser's telephone orders, which instructed the administration of "Humulin R 125 units" and a blood sugar check before meals and bedtime due to Resident A's diabetes mellitus type 2. Also, if blood sugar parameters for Resident A were below 65 or greater than 270, the physician was to be called. It was not clarified whether to administer U-100 or the U-500 concentration of Humulin R.

9. Respondent then documented on the Injectable Sheet for Resident A:

A. Line 5- "9/21/09 Blood Sugars <65 or >270 call M.D. FYI"

B. Line 6-"9/21/09 Humulin R give 125 units SQ before breakfast, lunch + dinner + H.S." Above this was written"500units/mL." The "500 units/mL"

was then crossed off by Respondent with the word error written above it. Next to it was written "100u/mL."

10. At 9:00 p.m. that night, Respondent documented in the nursing notes, "Resident with blood sugar watch. Resident with orders clarified per Glaser."

11. On or around September 22, 2009 at 7:00 a.m., Waters nurse, Jill Wood, RN (formerly Dennett) administered a dose of 625 units of Humulin R insulin—an amount five times greater than the ordered dose.

12. At 12:00 p.m., Wood overdosed Resident A for a second time, administering another 625 units of the Humulin R U-500 insulin. Wood informed Respondent of the dosage given to Resident A. Respondent informed Wood that the amount given was incorrect. Wood then contacted Dr. Glaser prior to administration, but nevertheless misunderstood the concept that a "unit of insulin" is an independent measure from the "volume of medication," depending on the concentration of Humulin R.

13. At 1:00 p.m., Wood wrote a clarification order stating, "Humulin R 500 units/mL - 125 SQ before meals per Dr. Glaser." In addition, Wood indicated in the nursing notes, "Called Dr. Glaser earlier to clarify orders for Humulin R insulin order. I asked if we are giving 500 units/mL vs 100 units/mL. Per Dr. Glaser 'I prefer 500 + to continue (with) 125 units SQ AC.'"

14. On or around 2:00 p.m., Respondent began her shift at Waters and learned that Resident A had received two excessive doses of insulin from Wood.

15. After the 1:00 p.m. nursing note entry by Wood, the next entry for Resident A is at 10:00 p.m. by Respondent. Midway through Respondent's entry, "3pm" is written next to the part of the entry that states, "Res (with blood sugar) @ 88 OJ given M.D. notified. ↑ 160. Res with injects held until AM per M.D. if sugar level ↓ 70 Give Dextrose 25g/015 g/mL From EDK.

If (not effective) give Dextrose I.V. D5½ NS. + call M.D. M.D. stated (with) reclarification please cont 125 unit of Humilin (sic) R 100u/mL (before) meals and (bedtimes) cont to monitor blood sugar. Res (with) call light (with) in reach."

16. Phone records show that Dr. Glaser returned Respondent's phone call around 9:09 p.m. This is the time at which Dr. Glaser recalls being informed that Resident A had received "1.25cc of R500, the equivalent of 625 units of insulin at suppertime. Blood sugars had somehow remained in the 80's, however." Dr. Glaser instructed that "for blood sugar below 70 despite snacks, he should receive an amp of D50W, and it was confirmed that the medication was available in the facility. For persistent hypoglycemia he would be treated with D5 ½ normal saline at 100 cc per hour with frequent blood sugar monitoring. If blood sugars tended to still remain below 70, he would be transferred to Margaret Mary Emergency Room. These instructions were given in the presence of my wife." On this day, Dr. Glaser recalls having a total of two discussions by phone with nursing staff at Waters explaining the equivalency of doses of the two types of insulin. He felt that his intentions were understood in that the patient was to "receive 125 units of insulin, which would be 1.25cc of standard insulin or 0.25cc of the R500."

17. Respondent wrote a clarification order with a time of 4:30 p.m., "Clarification Do not give Hum R 500 u/mL (change) to give Hum R 100u/mL 125 u/mL (before meals and bedtime). If blood sugar tonight (drops) below 70 give Dextrose 25g/015 g/mL from E.D.K. (and) if (not) eff(ective) give Dextrose IV (Dextrose 5 with ½ normal saline) and call M.D. Hold all insulin doses until A.M. Monitor (blood sugar).

18. Resident A's Blood Sugar Monitoring form indicates his blood sugar level was checked at 6:00 a.m. 11:00 a.m., 4:00 p.m., and 9:00 p.m. on September 22, 2009. According to

Dr. Glaser's "Emergency Room History and Physical," the nurses at Waters who were responsible for Resident A after Respondent's shift did not check his blood sugar due to a misunderstanding as to which one was responsible for this duty.

19. Despite Resident A's blood sugar concern, Respondent failed to document blood sugar checks other than at 4:00 p.m. and 9:00 p.m. Although Respondent's shift ended at 10:00 p.m., Respondent remained afterward to complete nursing documentation.

20. On or around September 23, 2009 at 12:30 a.m., Nurse Amie Brown documented that Resident A was alert and oriented to person, time, and place, no complaints.

21. On or around September 25, 2009, Waters issued Respondent a written warning for poor work performance/not following department procedures. Respondent had previously documented an order for Nov 70/30 insulin. The supervisor informed Respondent that she needed to be specific with the type of insulin (Novolog or Novolin) because a clarification order has to be written to fix the order she had documented.

22. Respondent's employment with Waters ended on October 9, 2009.

23. In September of 2011, Respondent enrolled in the Registered Nurse Program at Cincinnati State.

24. Since April 19, 2012, Respondent has been working at Ridgewood Health Campus located in Lawrenceburg, Indiana without incident (See Exhibit "B").

25. In December of 2012, Respondent completed her classes at for the Registered Nurse Program at Cincinnati State in anticipation for her graduation date of May 2013. As part of her curriculum, Respondent completed education in the area of diabetic care. (See Exhibit "C").

26. In March 2013, the Ohio Board of Nursing approved Respondent to take the NCLEX exam on April 10, 2013.

STIPULATED CONCLUSIONS OF LAW

The parties further stipulate:

1. Respondent's conduct violated Ind. Code §25-1-9-4(a)(4)(B).

AGREED DISPOSITION

It is now therefore agreed by Respondent and the Petitioner as follows:

1. The Board has jurisdiction over Respondent and the subject matter in this disciplinary action.

2. The parties execute this Agreement voluntarily.

3. Both parties voluntarily waive their rights to a public hearing on the Complaint.

4. Petitioner agrees that the terms of this Agreement will resolve any and all pending claims or allegations relating to disciplinary action against Respondent's Indiana nursing license.

5. Respondent agrees that her Indiana nursing license shall receive a **Letter of Reprimand** attached hereto as "Exhibit A."

6. Respondent agrees that within ninety (90) days of the Final Order, Respondent shall submit to IPLA proof of completion of twelve (12) contact hours of continuing education in the area of Professionalism/Ethics. As part of the discipline against Respondent's license, the Board will take into consideration, Respondent's subsequent education and work performance since the incidents described in the above stipulated facts.

7. All documentation to be submitted to the Board/IPLA, including continuing education, shall be sent to the following address:

Indiana Professional Licensing Agency
Attn: Nursing, Group 2

402 West Washington Street, Room W072
Indianapolis, IN 46204

8. Within ninety (90) days, Respondent shall, pursuant to Ind. Code § 4-6-14-10 (b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund This fee shall be paid by check or money order payable to the State of Indiana, and submitted to the following address:

Indiana Office of the Attorney General
Attn: Katherine Thorpe
302 West Washington Street, 5th Floor
Indianapolis, IN 46204

9. Respondent has carefully read and examined this agreement and fully understands its terms and that, subject to a final order issued by the Board, this Agreement is a final disposition of all matters and not subject to further review.

10. Respondent further understands that a violation of the Final Order, any non-compliance with the statutes or regulations regarding the practice of nursing, or any violation of the Settlement Agreement may result in the State requesting an emergency suspension of Respondent's license, an Order to Show Cause as may be issued by the Board, or a new cause of action pursuant to Ind. Code § 25-1-9-4, any or all of which could lead to additional sanctions, up to and including a revocation of Respondent's license.

11. The parties agree to the continuing jurisdiction of the Board and that the discipline agreed to, terms of discipline, and licensure status will apply even if the Board renews Respondent's license at a later date.

Tina Marie Batchelor, R.N. 4/17/13
Tina Marie Batchelor, R.N. Date
Respondent

402 West Washington Street, Room W072
Indianapolis, IN 46204

8. Within ninety (90) days, Respondent shall, pursuant to Ind. Code § 4-6-14-10 (b), pay a fee of Five Dollars ($5.00) to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund This fee shall be paid by check or money order payable to the State of Indiana, and submitted to the following address:

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_____ _____

Tina Marie Batchelor, R.N. Date
Respondent

Adam Clay
Counsel for Respondent

4/17/13
Date

Matt Black
Counsel for Respondent

4-17-2013
Date

Laura E. Wilford
Deputy Attorney General

4/18/13
Date

_____, 2013

Indiana Professional Licensing Agency

Board of Nursing
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Phone: (317) 234-2043
Website: PLA.IN.gov

Governor Michael R. Pence

Executive Director Virgil R. Madden

Tina Marie Batchelor, L.P.N.
4827 E. 200 N.
Milan, Indiana 47031

Re: State of Indiana v. Tina Marie Batchelor, L.P.N.
Before the Indiana State Board of Nursing
Cause Number: 2013 NB 007

Dear Ms. Batchelor:

This letter of reprimand is issued as part of the settlement agreement reached between you and the State resulting from charges filed by the Office of the Attorney General on or about January 17, 2013 with the Indiana State Board of Nursing.

The purpose of this reprimand is to stress the important responsibility that you have by reason of possessing a license to practice as a nurse in the State of Indiana. The Findings of Fact, Conclusions of Law and Order are attached and incorporated herein as part of this reprimand.

It is your responsibility to conduct your practice of nursing in accordance with the standards of the profession.

Sincerely,

INDIANA STATE BOARD OF NURSING

By: _____
Virgil R. Madden, Executive Director
Professional Licensing Agency

Exhibit
A