BEFORE THE INDIANA STATE
BOARD OF NURSING
CAUSE NUMBER: 2005 NB 0145

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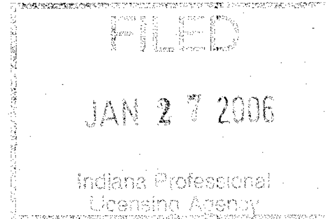
| STATE OF INDIANA, | ) |
| Petitioner, | ) |
| | ) |
| v. | ) |
| | ) |
| DEBORAH A. SEAVER, R.N., | ) |
| LICENSE NUMBER: 28117716, | ) |
| | ) |
| Respondent. | ) |




## SETTLEMENT, FINDINGS OF FACT, ULTIMATE FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Indiana State Board of Nursing ("Board") presided over a settlement conference on December 15, 2005 regarding the complaint filed on July 29, 2005 against Deborah A. Seaver, R.N., ("Respondent").

The State of Indiana was represented by Daniel J. Cavallini, Deputy Attorney General. Respondent was represented by Andrew Dutkanych III.

The State presented the terms of this Settlement, Findings of Fact, Ultimate Findings of Fact, Conclusions of Law, and Order ("Settlement") to the Board for its consideration. The Board, by a vote of 6-0-0, accepted and approved the following proposed settlement and order.

## FINDINGS OF FACT

The parties stipulate that the following facts are true and accurate:

1. Respondent's address on file with the Board is 4799-C Scenic Drive, Newburgh, Indiana, 47630.

2. Respondent is a duly licensed registered nurse having been issued Indiana license number 28117716.

3. Respondent was employed by Deaconess Hospital in Evansville, Indiana from on or about July 27, 1992 through on or about June 23, 1994.

4. On or about December 6, 1993, Respondent was given a written warning for several medication errors and documentation errors.

5. On or about January 5, 1994, Respondent was given a written warning after Respondent administered an order of Dilantin 400mg to a patient and did not record it in the Medication Administration Record ("MAR") and did not notify the LPN who was administering medication for the patient that the medication had been given. As a result, the patient received two (2) doses of the medication. Further, Respondent wrote a report that was not complete and suggested that she had recorded the medication administration, but that the LPN had not checked the MAR before giving the medication.

6. On or about June 23, 1994, Respondent was terminated from Deaconess Hospital due to failure to demonstrate safe nursing practice specifically related to medication administration. Respondent administered medication, which was not to be given 24 hours prior to surgery, to a patient who was scheduled for surgery the next morning. Respondent failed to check the patient's lab work or verify any change in the scheduled surgery time prior to administering the medication. Further, Respondent failed to document patient assessment of a patient on Demerol, failed to record the administration of medication, and failed to control narcotics.

7. Respondent was employed by the Holiday Care Center in Evansville, Indiana from on or about December 1994 until on or about January 10, 2002.

8. Respondent had at least eighteen (18) documented medication errors between on or about January 1995 and January 2002.

9. During her employment at Holiday Care Center, Respondent was issued several written reprimands regarding her professionalism, her communication and behavior in front of residents and their families, her failure to follow up to ensure her job is done properly, and her overall work performance.

10. On or about February 10, 1998, Respondent exposed herself to a resident. When questioned, Respondent indicated she had shown the resident her "backside" in response to the resident's comments with respect to Respondent's tan.

11. On or about February 13, 1998, Respondent allegedly spilled juice on her uniform top and subsequently removed her shirt, sitting at a desk with a sports bra.

12. On or around May 11, 2001, while at Holiday Care Center, Respondent was reprimanded for verbal, physical, and psychological abuse of a patient when she pulled a resident's mouth open and to one side while administering a treatment and stated, "This is like cleaning a toilet."

13. On or about August 20, 2001, Respondent was issued a written reprimand for passive neglect of a patient in that she failed to refill and turn on a resident's feeding tube.

14. On or about August 20, 2001, Respondent was cited for passing medications over an hour and forty-five minutes late because she was outside smoking.

15. Between on or about August 20, 2001 and September 3, 2001, Respondent was reprimanded for failure to accurately fill out patient reports, failure to contact a treating physician and notify the family of a patient of measures taken that affect the patient's treatment, failure to document and contact family members about a patient's fall, failure to keep a record of her notes regarding a patient's treatment, and failure to notify the physician and family members of a change in patient status.

16. On or about January 10, 2002, Respondent was terminated from Holiday Care Center after failing to return to work at the end of her allowed time under the Family Medical Leave Act.

17. Respondent was employed at Cypress Grove Rehabilitation Center ("Cypress Grove") in Newburgh, Indiana between on or about August 15, 2002 and October 25, 2002.

18. On or about October 25, 2002, Respondent was terminated from Cypress Grove after Respondent instructed an LPN to remove a PICC line. Respondent was PICC line certified but was not certified as a PICC line instructor.

19. On or about October 7, 2003, Respondent completed her license renewal. Respondent answered "NO" to all questions, including #5: "Have you been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or as another health care professional?"

## ULTIMATE FINDINGS OF FACT

1. Respondent violated IND. CODE §25-1-9-4(a)(1)(A) in that Respondent engaged in or knowingly cooperated in fraud or material deception in order to obtain a license to practice.
2. Respondent violated IND. CODE §25-1-9-4(a)(3) in that Respondent knowingly violated a rule regulating the nursing profession, to wit: 848 IAC 2-2-3(1) Respondent used unsafe judgment, technical skills, or inappropriate interpersonal behaviors in providing nursing care.
3. Respondent violated IND. CODE §25-1-9-4(a)(3) in that Respondent knowingly violated a rule regulating the nursing profession, to wit: 848 IAC 2-2-3(8) Respondent delegated nursing care, functions, tasks, or responsibility to others when the nurse knew, or should have known, that such delegation is to the detriment of the patient's safety.
4. Respondent violated IND. CODE §25-1-9-4(a)(3) in that Respondent knowingly violated a rule regulating the nursing profession, to wit: 848 IAC 2-2-3(5) Respondent abused a patient/client verbally.
5. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(4)(B) in that Respondent failed to keep abreast of current professional theory or practice.
6. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulations, regulating the profession in question, to wit: 848 IAC 2-2-2(5), Respondent failed to respect the dignity and rights of the patient/client regardless of socioeconomic status, personal attributes, or nature of health problems.
7. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(3) in that

Respondent knowingly violated any state statute or rule, or federal statute or regulations, regulating the profession in question, to wit: 848 IAC 2-2-3(3), Respondent disregarded a patient/client's dignity, right to privacy, or right to confidentiality.

8. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulations, regulating the profession in question, to wit: 848 IAC 2-2-2(3), Respondent failed to communicate, collaborate, and function with other members of the health care team to provide safe and effective care.
9. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(4)(A)(C) in that Respondent continued to practice although she was unfit to practice due to physical or mental disability.
10. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(5) in that Respondent engaged in a course of lewd or immoral conduct in connection with the delivery of services to the public.
11. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(3) in that Respondent knowingly violated any state statute or rule, or federal statute or regulations, regulating the profession in question, to wit: 848 IAC 2-2-2(4), Respondent failed to seek education and supervision as necessary when implementing nursing practice techniques.
12. Respondent's conduct constitutes a violation of IND. CODE § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulations, regulating the profession in question, to wit: 848 IAC 2-2-2(8), Respondent failed to delegate and supervise only those nursing measures which the nurse knows, or should know, that another person is prepared, qualified, or licensed to perform.

## CONCLUSIONS OF LAW

1. Respondent's failure to comply with the above referenced standards is cause for disciplinary sanctions which may be imposed singly or in combination such as censure, a letter of reprimand, probation, suspension, or a revocation of license, and a fine up to the amount of $1000.00 per violation, as detailed at IND. CODE § 25-1-9-9 and IND. CODE § 25-23-1-7.

## ORDER

Based upon the above Findings of Fact, Ultimate Findings of Fact, and Conclusions of Law, the Board issues the following Order:

1. Respondent's Indiana Nursing license is placed on **INDEFINITE PROBATION**, and she may not petition the Board for withdrawal of probation for a period of **FOUR YEARS** from the date of this Order.
2. During this period of probation, Respondent's license is governed by the following **TERMS AND CONDITIONS:**
    a. Respondent, having submitted to a psychological evaluation, the evaluator has recommended no pharmacotherapy or treatment beyond what this Order requires unless there is a recurrence in judgment problems. In the event there is a recurrence in judgment problems, as evidenced by either her employer reports or any other violations of statute, rule, or regulation, the Respondent shall submit to a re-evaluation and comply with any therapy and/or treatment recommendations;
    b. Respondent shall keep the Board informed of her current residential address and telephone number, including changes thereto;

c. Respondent shall keep the Board informed of her current employer and employer's address and telephone number, including changes thereto;

d. Within ten (10) days of the Board's written Order, Respondent shall submit a copy of this Agreement and Order to the Board bearing the signature of her employer;

e. Respondent shall cause her nursing supervisor to submit monthly reports to the Board during the Respondent's first year of probation, and quarterly reports thereafter for the remainder of her probation. Such reports shall contain Respondent's nursing supervisor's opinion regarding Respondent's:

   (i) professional competence,

   (ii) sense of responsibility,

   (iii)work habits,

   (iv)mental attitude, and

   (v) ability to work with others;

f. Respondent shall perform six (6) hours of community service, of which three (3) hours shall be performed in conjunction with an accredited nursing training program discussing the implications of patient abuse and lessons learned from her disciplinary experience with nursing students;

g. Verification of satisfactory performance of community service shall be delivered to the Board pursuant to the following timelines:

   1. Three (3) hours performed in conjunction with an accredited nursing training program discussing the implications of patient

abuse and lessons learned shall be completed within one (1) year from the date of this Order;

2. The remaining three (3) hours shall be completed within two (2) years from the date of this Order;

h. Respondent shall perform three (3) hours of ethics training relating to the practice of nursing within three (3) months of the date of this Order;

i. Respondent shall perform three (3) hours of training relating to standards of nursing practice and/or care within three (3) months of the date of this Order;

j. Respondent shall perform three (3) hours of training relating to proper documentation of medication dispensing within nine (9) months of the date of this Order;

k. Respondent shall perform three (3) hours of training relating to patient behavioral intervention within eighteen (18) months of the date of this Order;

l. Respondent shall perform three (3) hours of training relating to the care of elderly patients within eighteen (18) months of the date of this Order;

m. Verification of satisfactory performance of continuing education shall be delivered to the board within the time period allotted for each individual continuing education requirement;

n. Respondent shall enroll in and complete a class in anger management;

o. Verification of satisfactory performance of anger management shall be delivered to the board upon its completion;

p. Respondent shall pay a fine of two hundred fifty dollars ($250.00), payable by cashier's check or money order to the Indiana Professional Licensing Agency,

402 West Washington Street, Room W072, Indianapolis, Indiana 46204, within two (2) years of the date of this Order;

3. Failure to comply with the terms of this Order, or any violation of the rules, regulations or statutes governing the practice of nursing may subject Respondent to an order to show cause, summary suspension, revocation or other discipline.

SO ORDERED this 27 day of January 2006.

INDIANA STATE BOARD OF NURSING

By:
Frances L. Kelly
Executive Director
Indiana Professional Licensing Agency

Copies to:

Deborah A. Seaver, R.N.
4799-C Scenic Drive
Newburgh, IN 47630
**CERTIFIED MAIL NUMBER: 7002 2410 0002 4164 8751**
**RETURN RECEIPT REQUESTED.**

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