

**Indiana  
Professional  
Licensing  
Agency**



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

Michael R. Pence, Governor

Nicholas Rhoad, Executive Director

**ANNUAL REPORT FOR PROGRAMS IN NURSING**

**Guidelines:** An Annual Report prepared and submitted by the faculty of the school of nursing, will provide the Indiana State Board of Nursing with a clear picture of how the nursing program is currently operating and its compliance with the regulations governing the professional and/or practical nurse education program(s) in the State of Indiana. The Annual Report is intended to inform the Education Subcommittee and the Indiana State Board of Nursing of program operations during the academic reporting year. This information will be posted on the Board's website and will be available for public viewing.

**Purpose:** To provide a mechanism to provide consumers with information regarding nursing programs in Indiana and monitor complaints essential to the maintenance of a quality nursing education program.

**Directions:** To complete the Annual Report form attached, use data from your academic reporting year unless otherwise indicated. An example of an academic reporting year may be: August 1, 2012 through July 31, 2013. Academic reporting years may vary among institutions based on a number of factors including budget year, type of program delivery system, etc. Once your program specifies its academic reporting year, the program must utilize this same date range for each consecutive academic reporting year to insure no gaps in reporting. You must complete a **SEPARATE report** for each PN, ASN and BSN program.

This form is due to the Indiana Professional Licensing Agency by the close of business on October 1st each year. The form must be electronically submitted with the original signature of the Dean or Director to: PLA2@PLA.IN.GOV. Please place in the subject line "Annual Report (Insert School Name) (Insert Type of Program) (Insert Academic Reporting Year). For example, "Annual Report ABC School of Nursing ASN Program 2013." The Board may also request your most recent school catalog, student handbook, nursing school brochures or other documentation as it sees fit. It is the program's responsibility to keep these documents on file and to provide them to the Board in a timely manner if requested.

Indicate Type of Nursing Program for this Report:      PN \_\_\_\_\_      ASN \_\_\_\_\_      BSN   X  

Dates of Academic Reporting Year: September 3, 2013- September 3, 2014  
(Date/Month/Year) to (Date/Month/Year)

Name of School of Nursing: Anderson University School of Nursing

Address: 1100 East Fifth Street, Anderson, IN 46012

Dean/Director of Nursing Program

Name and Credentials: Dr. Karen Selwa Williams DNP, MSN, APRN, ANP-C

Title: Dean, School of Nursing, Kinesiology, and Behavioral Sciences

Email: kswilliams@anderson.edu



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Nursing Program Phone #: 765-641-4385 Fax: 765-641-4389

Website Address: <http://www.anderson.edu/academics/nursing>

Social Media Information Specific to the SON Program (Twitter, Facebook, etc.): Anderson University School of Nursing maintains a Facebook page, Twitter, and Nursing Blog.

Please indicate last date of NLNAC or CCNE accreditation visit, if applicable, and attach the outcome and findings of the visit: Accreditation by the CCNE for a 10 year period of time was granted in April 2006. The next site visit of the CCNE will be Fall 2015.

If you are not accredited by NLNAC or CCNE where are you at in the process? \_\_\_\_\_

**SECTION 1: ADMINISTRATION**

Using an "X" indicate whether you have made any of the following changes during the preceding academic year. For all "yes" responses you must attach an explanation or description.

- 1) Change in ownership, legal status or form of control Yes \_\_\_\_\_ No X
- 2) Change in mission or program objectives Yes \_\_\_\_\_ No X
- 3) Change in credentials of Dean or Director Yes \_\_\_\_\_ No X
- 4) Change in Dean or Director Yes \_\_\_\_\_ No X
- 5) Change in the responsibilities of Dean or Director Yes X No \_\_\_\_\_

To increase synergy and interprofessional development and collaboration, Dr. Williams was appointed the Dean of Nursing, Kinesiology, and Behavioral Sciences. Lynn Schmidt was appointed Associate Dean of the School of Nursing

- 6) Change in program resources/facilities Yes \_\_\_\_\_ No X
- 7) Does the program have adequate library resources? Yes X No \_\_\_\_\_
- 8) Change in clinical facilities or agencies used (list both additions and deletions on attachment) Yes \_\_\_\_\_ No X



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9) Major changes in curriculum (list if positive response) Yes \_\_\_\_\_ No X

**SECTION 2: PROGRAM**

1A.) How would you characterize your program's performance on the NCLEX for the most recent academic year as compared to previous years? Increasing \_\_\_\_\_ Stable X Declining \_\_\_\_\_

1B.) If you identified your performance as declining, what steps is the program taking to address this issue?  
\_\_\_\_\_  
\_\_\_\_\_

2A.) Do you require students to pass a standardized comprehensive exam before taking the NCLEX?  
Yes \_\_\_\_\_ No X

2B.) If not, explain how you assess student readiness for the NCLEX. We do require students to take the Kaplan Review Course which contains a readiness test. We also require students to take the ATI readiness test. We do not require students to "pass" these tests before taking NCLEX. Obviously it is highly desirable- however, we cannot withhold graduation on the basis of failing a readiness test.

2C.) If so, which exam(s) do you require?  
\_\_\_\_\_

2D.) When in the program are comprehensive exams taken: Upon Completion \_\_\_\_\_  
As part of a course NURS 4520 Ties to progression or thru curriculum \_\_\_\_\_

2E.) If taken as part of a course, please identify course(s): NURS 4520 (Senior Year, Spring Semester)

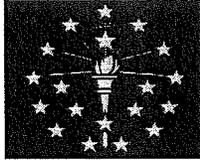
3.) Describe any challenges/parameters on the capacity of your program below:

A. Faculty recruitment/retention: It is very challenging to recruit doctorally prepared faculty members. Must hire BSN and enroll in MSN programs (Grow Our Own).

B. Availability of clinical placements: Competition for clinical placement is fierce, especially in small units- OB, PEDS, Mental Health. Unfair advantages given to some universities by some hospitals- preference given to their students over others.

C. Other programmatic concerns (library resources, skills lab, sim lab, etc.): None

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4.) At what point does your program conduct a criminal background check on students? A criminal background check is required upon entering the clinical nursing courses at the beginning of the sophomore year of study.

5.) At what point and in what manner are students apprised of the criminal background check for your program? Students are informed that it is required before they apply to the sophomore year. Questionable results of the background check are discussed with every student by the

**SECTION 3: STUDENT INFORMATION**

1.) Total number of students admitted in academic reporting year:

Fall 2012-2013: 70 Students

Fall 2013-2014: 64 Students

2.) Total number of graduates in academic reporting year:

Spring 2013-2014: 26 Students

3.) Please attach a brief description of all complaints about the program, and include how they were addressed or resolved. For the purposes of illustration only, the CCNE definition of complaint is included at the end of the report.

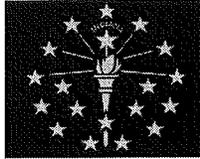
4.) Indicate the type of program delivery system:

Semesters      X      Quarters      Other (specify):     

**SECTION 4: FACULTY INFORMATION**

A. Provide the following information for **all faculty new** to your program in the academic reporting year (attach additional pages if necessary):

<b>Faculty Name:</b>	Jeralene J Hudson
<b>Indiana License Number:</b>	28171351A



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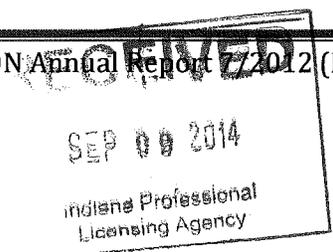
Nicholas Rhoad, Executive Director

<b>Full or Part Time:</b>	Full-time
<b>Date of Appointment:</b>	June 18, 2014
<b>Highest Degree:</b>	BSN (Currently enrolled in MSN program)
<b>Responsibilities:</b>	Simulation Lab, Clinical, Classroom

<b>Faculty Name:</b>	Patricia A. Kline
<b>Indiana License Number:</b>	28072081A
<b>Full or Part Time:</b>	Full-time
<b>Date of Appointment:</b>	July 25, 2014
<b>Highest Degree:</b>	MSN, Nurse Midwifery Certification
<b>Responsibilities:</b>	Simulation Lab, Clinical, Classroom

<b>Faculty Name:</b>	D. Nehemiah Bailey
<b>Indiana License Number:</b>	28191773A
<b>Full or Part Time:</b>	Part-time
<b>Date of Appointment:</b>	January 13, 2014
<b>Highest Degree:</b>	BSN( Currently enrolled in MSN/MBA program)
<b>Responsibilities:</b>	Simulation Laboratory, Clinical

<b>Faculty Name:</b>	Wendy A. Buck
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<b>Indiana License Number:</b>	28181102A
<b>Full or Part Time:</b>	Part-time
<b>Date of Appointment:</b>	6/18/2014
<b>Highest Degree:</b>	BSN
<b>Responsibilities:</b>	Simulation Laboratory, Clinical

<b>Faculty Name:</b>	Candice Closser
<b>Indiana License Number:</b>	28174248A
<b>Full or Part Time:</b>	Part-time
<b>Date of Appointment:</b>	June 26, 2014
<b>Highest Degree:</b>	BSN
<b>Responsibilities:</b>	Simulation Laboratory, Clinical

<b>Faculty Name:</b>	Jessica C. Sparks
<b>Indiana License Number:</b>	28174615A; NP) 71004639A
<b>Full or Part Time:</b>	Part-time
<b>Date of Appointment:</b>	July 9, 2014
<b>Highest Degree:</b>	MSN, ANP
<b>Responsibilities:</b>	Simulation Laboratory, Clinical



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**B. Total faculty teaching in your program in the academic reporting year:**

1. Number of full time faculty: 10, Plus 1 Dean
2. Number of part time faculty: 0
3. Number of full time clinical faculty: 0
4. Number of part time clinical faculty: 10
5. Number of adjunct faculty: 1

**C. Faculty education, by highest degree only:**

1. Number with an earned doctoral degree: 1(Dean - DNP), 1 (Associate Dean-PhD (c)
2. Number with master's degree in nursing: 7, One with MSN, Ed, (Full-time only), 2 Part-time
3. Number with baccalaureate degree in nursing: 2 (Full-time) enrolled in MSN program; 8 (Part-time) enrolled in MSN Program, and 2 Part-time)
4. Other credential(s). Please specify type and number: 2 MSN/MBA, 2 NP, and 1Midwifery Certification

**D. Given this information, does your program meet the criteria outlined in 848 IAC 1-2-13 or 848 IAC 1-2-14?**

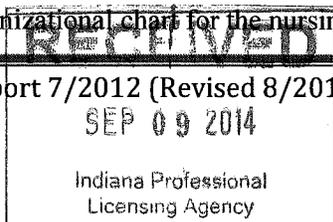
Yes  No

**E. Please attach the following documents to the Annual Report in compliance with 848 IAC 1-2-23:**

1. A list of faculty no longer employed by the institution since the last Annual Report;

Cheryl Vincent (Resigned due to family health problems, and Joy Weller (Resigned to become a consultant), May 2014

2. An organizational chart for the nursing program and the parent institution.





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I hereby attest that the information given in this Annual Report is true and complete to the best of my knowledge. This form **must** be signed by the Dean or Director. No stamps or delegation of signature will be accepted.

*Dr. Karen Selwa Williams*

9-8/14

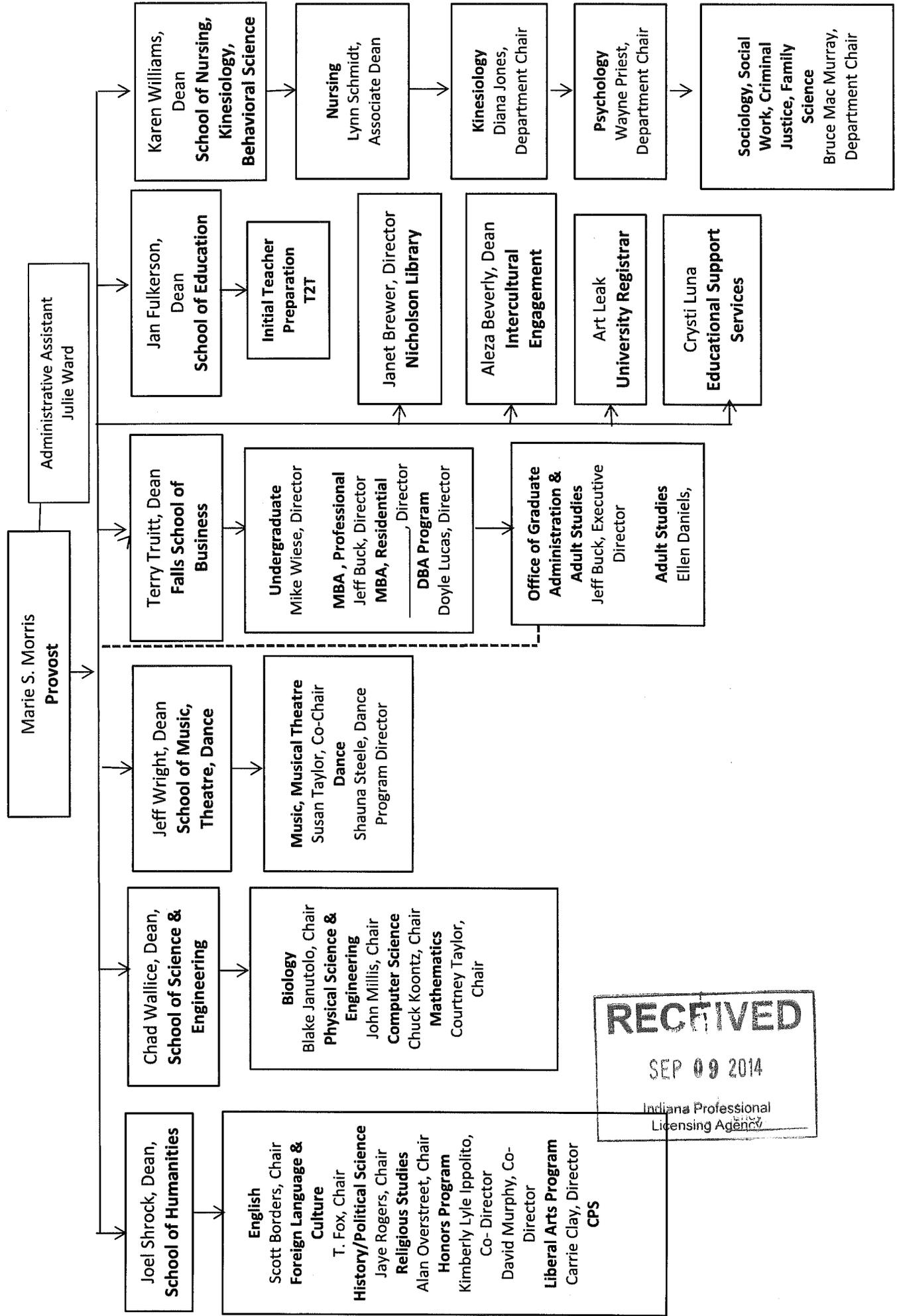
Signature of Dean/Director of Nursing Program

Date

KAREN Selwa Williams

Printed Name of Dean/Director of Nursing Program

Please note: Your comments and suggestions are welcomed by the Board. Please feel free to attach these to your report.



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