

**BEFORE THE OREGON
STATE BOARD OF NURSING**

In the Matter of Regina Curtis, RN) STIPULATED ORDER FOR) REPRIMAND WITH CONDITIONS) OF REGISTERED NURSE LICENSE))
License No. 084060988RN) Reference No. 11-02675

Regina Curtis (Licensee) was issued a Registered Nurse license by the Oregon State Board of Nursing (Board) on March 17, 1986.

On or about March 28, 2011, the Board received information that Licensee failed to assess or intervene to keep residents safe from harm after staff reported a sexual encounter that occurred between two residents. A second allegation was that Licensee failed to maintain a safe medication administration system on or around February 4, 2011.

An Adult Protective Services (APS) report, dated March 1, 2011, substantiated that Licensee failed to assess and intervene to keep two residents safe from sexual abuse after she received a report that on or around February 20, 2011, a male resident was found naked in bed with a female resident who was diagnosed with Dementia. Licensee did not interview the residents to evaluate for abuse or report the incident to the family, physicians, or APS.

A second APS report, dated March 8, 2011, substantiated that on or around February 4, 2011, Licensee failed to maintain a safe medication system when she was made aware that a Medication Aide (MA) was impaired at work. Licensee allowed the MA to continue to work. The MA made a medication error which Licensee did not document or report to the resident's physician.

On May 10, 2011, Licensee met with Board staff to discuss the allegations. Licensee stated she did not notify APS of the sexual encounter between two residents because she considered the encounter to be consensual. Licensee acknowledged that she made this determination without interviewing either resident and despite one resident's diagnosis of dementia. Licensee also acknowledged that she did not complete an incident report regarding a medication error, which the MA acknowledged was made. She stated she did not report the error to the resident's physician because the resident spit the pill out.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1) (f); and OAR 851-045-0070 (1) (a) and (b) and (g); and (2) (d) and (e); and (3) (h) and (i) which read as follows:

678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

851-045-0070 Conduct Derogatory to the Standards of Nursing Defined

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

(b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.

(g) Failing to supervise persons to whom nursing tasks have been assigned.

(2) Conduct related to other federal or state statute/rule violations:

(d) Failing to report actual or suspected incidents of client abuse through the proper channels in the work place and to the appropriate state agencies.

(e) Failing to report actual or suspected incidents of child abuse or elder abuse to the appropriate state agencies.

(3) Conduct related to communication:

(h) Failing to communicate information regarding the client's status to members of the health care team (physician, nurse practitioner, nursing supervisor, nurse co-worker) in an ongoing and timely manner; and

(i) Failing to communicate information regarding the client's status to other individuals who need to know; for example, family, and facility administrator.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Registered Nurse license of Regina Curtis be reprimanded and that she complete 9.0 continuing education hours on Nursing Ethics and Professionalism and Medications Errors.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

Regina Curtis, RN

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

Kay Carnegie, RN, MS
Board President

Date