The attached are Primary Source Documents of the Idaho Board of Nursing for:

JEANNETTE YORK
N-10177

Idaho Board of Nursing – PO Box 83720 – Boise, Idaho 83720-0061 – (208) 334-3110
May 2, 1996

CERTIFIED MAIL

Jeannette York
615 White Cloud Drive
Boise ID  83709

Dear Ms. York:

Upon formal action by the Idaho Board of Nursing on May 2, 1996, your professional nurse license N-10177, was indefinitely suspended. Enclosed are the Findings of Fact and Conclusions of Law.

You may not practice nursing in the State of Idaho during the time your license is indefinitely suspended. Please return your current certificate by return mail.

Sincerely,

SANDRA EVANS, M.A.Ed., R.N.
Interim Executive Director

SE:lhc
enclosure
BEFORE THE BOARD OF NURSING, STATE OF IDAHO

In the matter of

Jeannette Anne Campbell
YORK
License No: N-10177

FINDINGS
OF
FACT
CASE #: 95-51

Based upon information in the Board of Nursing files, the Board finds that:

1. Jeannette Anne Campbell York was issued professional nurse license number N-10177 on August 15, 1973 pursuant to qualifications specified in the Idaho Nursing Practice Act. The licensee holds a current licensure certificate, number N-10177, which expires August 31, 1997.

2. A Complaint for Revocation or Suspension of License was initiated by the Board of Nursing on February 29, 1996, was delivered by certified mail and was signed for on March 2, 1996. The Answer to Complaint was not returned and no hearing was requested.

3. On or about August 19-20, 1991, while employed as a nursing consultant for Dawson PSI, was unable to account for 19 doses of Percocet.

4. On or about March - April, 1991 while employed as a registered nurse at Franciscan Care, Boise, Idaho demonstrated erratic behavior: sitting with coffee trying to document a list of treatments to be done, working overtime to complete job responsibilities, inability to replace a gastric tube, "losing her cool".

5. A drug/alcohol evaluation completed October 23, 1991, by the Nelson Institute, noted warning signs of a chemical use problem and recommended 32 hours of alcohol drug information and random urine drug screens. The licensee signed an Agreement for Monitoring November 28, 1991, to be in effect until the end of the professional nurse licensure period, August 31, 1993. Completion of the drug alcohol education was reported June 3, 1992. A urine drug screen collected June 24, 1993, on the way to work was reported positive for urine alcohol at 0.05 level. The licensee admitted to drinking coke and vodka around 2 AM. An updated drug/alcohol evaluation was requested and the licensee was referred to the Board of Nursing's Advisory Committee.

6. A psychological evaluation of November 9, 1993, reported no memory problems or problems in higher levels of reasoning. The Board of Nursing's Advisory Committee cautioned the licensee on prescription and alcohol use due to vulnerability for chemical abuse during a meeting on December 16, 1993.
7. A drug alcohol evaluation completed December 13, 1995, at The Nelson Institute noted signs and symptoms of increased prescription use and recommended further review.

8. On or about September 1994 - June 8, 1995, while employed as a registered nurse at Midland Care Center, Nampa, Idaho, left the medication cart and the medication room door open and unattended; on one occasion was shaky and could hardly turn pages during drug count -got mixed up on the count and did not recognize that the second counter had left a short time to respond to an emergency; failed at least six times to check the emergency cart; left the facility on one occasion without proper notification, leaving the facility without Registered Nurse coverage contrary to facility licensure requirements; failed to document patient behavior that led to allowing the patient to sleep on a urine soaked couch; between April 19 - 29 and May 4-24, 1995, recorded fourteen (14) dosages of Soma i with Tylenol ii to a resident in his 80’s when other nurses recorded no complaints of pain or refusal of pain medication; failed to report to physician patient complaints of chest and leg pain; failed to adequately assess and document a resident’s complaint of severe abdominal pain; failed to account for two Tylox on her shift; neglected to label intravenous solutions with an antibiotic and failed to administer the IV solution as ordered.

During a meeting with the licensee on July 7, 1995, she stated she had three back surgeries, is in chronic pain but takes pain medication only during off duty hours, that she had not been counseled regarding some of the reported problems, two licensed practical nurses were present in the facility when she had to leave because of vomiting and diarrhea, she could not carry out some actions because some residents were combative with kicking and striking out, she was asked to consult only on residents not assigned to her.

9. On August 17, 1995, the Board of Nursing members reviewed summary information and authorized a Monitoring Agreement to be in effect until August 31, 1996. The licensee signed the Agreement on August 31, 1995. The Agreement required performance evaluations monthly for six months, then quarterly. At least four notices of deficient reports have been sent to the licensee (two by Certified Mail). No reports have been received. On February 9, 1996, a letter requesting the licensee to schedule an appointment for a meeting by February 16, 1996, was sent to the licensee. No response has been received from the licensee.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board of Nursing makes the following Conclusions of Law:

1. Pursuant to the Nursing Practice Act, Idaho Code, Title 54, Chapter 14, the Board of Nursing has jurisdiction over this matter.

2. By virtue of the Findings of Fact, the licensee was grossly negligent and
reckless in performing nursing functions, violated standards of conduct and practice as adopted by the Board of Nursing and has engaged in conduct of a character likely to endanger patients.

3. The acts specified in number 2 above, constitute grounds for disciplinary action under provisions in Idaho Code, 54-1412.a. (4), (7) and (8) and Board of Nursing Rules, IDAPA 23.01.01100.05, 08., 09.(g.,i.,j.); 23.01.01370.16, 18., 19., 22., 24. and 23.01.01401.01.(a.), 04.(a.ii.), 05.(e.,g.), 08. (c.), 11.(a.,c.)

4. That such conduct constitutes sufficient cause pursuant to the Nursing Practice Act to revoke or suspend the license, number N-10177, issued to Jeannette York to practice nursing in the State of Idaho.

ORDER

IT IS HEREBY ORDERED that the professional nurse license, number N-10177 issued to Jeannette Anne Campbell York, be and it hereby is indefinitely suspended subject to Subsequent Review under 54-1412 (c), IDAHO CODE.

BE IT FURTHER ORDERED, that to be eligible for consideration for licensure reinstatement, the following conditions must be met:

1. Submission of Performance Based Development Assessment tools and methodologies (PBDS) evaluation.
2. Submission of a current drug/alcohol evaluation from a qualified evaluator.
3. Medical report of current health status, including prescription drugs.
4. Evaluation from the Pain Clinic of narcotic prescription medication usage.
5. Employment history and performance reports from all employers since licensure suspension.

DATED THIS May 2, 1996

CHARLES MOSELEY, R.N., CRNA
Chairman
Idaho Board of Nursing

FINDINGS - 3
3. Article Addressed to:

JEANNETTE YORK
615 WHITE CLOUD DRIVE
BOISE ID 83709

4a. Article Number

4b. Service Type

Certified
Registered
Express Mail
Return Receipt for Merchandise
Insured
COD

5. Received By: (Print Name)

6. Signature (Addressee or Agent)

7. Date of Delivery

8. Addressee's Address (Only if requested and fee is paid)

Thank you for using Return Receipt Service.
February 29, 1996

CERTIFIED MAIL

Jeannette York
615 White Cloud Drive
Boise, ID 83709

Dear Ms. York:

Enclosed please find the Complaint for Revocation or Suspension of License initiated by the Board of Nursing and an Answer to Complaint.

Sincerely,

LEOLA DANIELS, M.S., R.N.
Executive Director

LD: lhc
enclosures
BEFORE THE BOARD OF NURSING, STATE OF IDAHO

In the matter of

Jeannette Anne Campbell
YORK

License No: N-10177

COMPLAINT FOR
REVOCATION OR
SUSPENSION OF
LICENSE
CASE NO: 95-51

COMES NOW, Complainant, Leola Daniels, R.N., Executive Director of the Idaho Board of Nursing, and requests the Board to revoke or suspend the license of Jeannette Anne Campbell York to practice nursing in the State of Idaho. This Complaint and these proceedings are instituted upon the following grounds:

That the licensee has been grossly negligent or reckless in performing nursing functions, violated standards of conduct and practice as adopted by the Board of Nursing and has engaged in conduct of a character likely to endanger patients by virtue of the following:

1. On or about August 19-20, 1991, while employed as a nursing consultant for Dawson PSI, was unable to account for 19 doses of Percocet.

2. On or about March - April, 1991 while employed as a registered nurse at Franciscan Care, Boise, Idaho demonstrated erratic behavior: sitting with coffee trying to document a list of treatments to be done, working overtime to complete job responsibilities, inability to replace a gastric tube, "losing her cool".

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4. A psychological evaluation of November 9, 1993, reported no memory problems or problems in higher levels of reasoning. The Board of Nursing’s Advisory Committee cautioned the licensee on prescription and alcohol use due to vulnerability for chemical abuse during a meeting on December 16, 1993.

5. A drug alcohol evaluation completed December 13, 1995, at The Nelson Institute noted signs and symptoms of increased prescription use and recommended further review.

6. On or about September 1994 - June 8, 1995, while employed as a registered nurse at Midland Care Center, Nampa, Idaho, left the medication cart and the medication room door open and unattended; on one occasion was shaky and could hardly turn pages during drug count - got mixed up on the count and did not recognize that the second counter had left a short time to respond to an emergency; failed at least six times to check the emergency cart; left the facility on one occasion without proper notification, leaving the facility without Registered Nurse coverage contrary to facility licensure requirements; failed to document patient behavior that led to allowing the patient to sleep on a urine soaked couch; between April 19 - 29 and May 4-24, 1995, recorded fourteen (14) dosages of Soma i with Tylenol ii to a resident in his 80’s when other nurses recorded no complaints of pain or refusal of pain medication; failed to report to physician patient complaints of chest and leg pain; failed to adequately assess and document a resident’s complaint of severe abdominal pain; failed to account for two Tylox on her shift; neglected to label intravenous solutions with an antibiotic and failed to administer the IV solution as ordered.

During a meeting with the licensee on July 7, 1995, she stated she had three back surgeries, is in chronic pain but takes pain medication only during off duty hours, that she had not been counseled regarding some of the reported problems, two licensed practical nurses were present in the facility when she had to leave because of vomiting and diarrhea, she could not carry out some actions because some residents were combative with kicking and striking out, she was asked to consult only on residents not assigned to her.

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schedule an appointment for a meeting by February 16, 1996, was sent to the licensee. No response has been received.

The undersigned Leola Daniels, believes that the described conduct of the licensee is in violation of Section 54-1412 (a) (4), (7), and (8) IDAHO CODE, and of Board of Nursing Rules, IDAPA 23.01.01100.05, 08., 09.(g,i,j); 23.01.01370.16., 18., 19., 22., 24., and 23.01.01401.01.(a), 04.(a.ii), 05.(e, g), 08.(c), 11.(a., c.)

DATED THIS 29th day of February, 1996.

[Signature]

LEOLA DANIELS, M.S., R.N.
Executive Director
Idaho Board of Nursing
PROOF OF SERVICE

I hereby swear that I have this 29th day of February, 1996, served the foregoing Complaint for Revocation or Suspension of License and Answer to Complaint upon all parties of record named in this proceeding, by mailing a copy thereof, certified mail, return receipt requested, properly addressed with postage prepaid, to:

JEANNETTE YORK
615 WHITE CLOUD DRIVE
BOISE, ID 83709

[Signature]
Leola Daniels, M.S., R.N.
Executive Director
Idaho Board of Nursing
SENDERT:
Complete Items 1 and/or 2 for additional services.
Complete Items 3, 4a, and 4b.
Print your name and address on the reverse of this form so that we can return this
card to you.
Attach this form to the front of the mailpiece, or on the back if space does not
permit.
Write "Return Receipt Requested" on the mailpiece below the article number.
The Return Receipt will show to whom the article was delivered and the date
delivered.

3. Article Addressed to:
JEANNETTE YORK
615 WHITE CLOUD DRIVE
BOISE ID 83709

4a. Article Number
P 478 708 127

4b. Service Type
☑ Certified
☐ Registered
☐ Express Mail
☐ Insured
☐ Return Receipt for Merchandise
☐ COD

5. Received By: (Print Name)

6. Signature: (Addresser or Agent)

7. Date of Delivery
3/2/96

Thank you for using Return Receipt Service.

Consult postmaster for fee.

Domestic Return Receipt