



STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF NURSING

IN THE MATTER OF THE LICENSE OF : Administrative Action
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MARIA SHEILA GALGO-RASHID, R.N. :
License # 26NR 15643500 : FINAL ORDER
: OF DISCIPLINE
:
TO PRACTICE NURSING IN THE :
STATE OF NEW JERSEY :
:

This matter was opened to the New Jersey State Board of Nursing ("Board") upon receipt of information which the Board has reviewed and upon which the following findings of fact and conclusions of law are made:

FINDINGS OF FACT

1. Maria Sheila Galgo-Rashid ("Respondent") is a Registered Professional Nurse (RN) in the State of New Jersey, and has been a licensee at all times relevant hereto.

2. Respondent was employed as a nurse at Nutley Kidney Clinic in Belleville, New Jersey from approximately June of 2012 through August of 2013. In August of 2013, the facility was closed by the Department of Health (DOH) because of inadequacies revealed by an inspection that took place on August 14, 2013.

3. An inspection by the Division of Consumer Affairs revealed that from May through August of 2013, on approximately sixteen days, there were insufficient supplies of Hectorol and Venofer, medications prescribed for patients undergoing dialysis.

4. On or about August 14, 2013, Ms. Galgo-Rashid documented administration of Hectorol to patients S.G. and R.D., although there was no Hectorol in the facility at the time. Ms. Galgo-Rashid claimed that she pre-documented administration of the Hectorol on that date, but then went to the medication room and found that the medication was not available. Ms. Galgo-Rashid claimed that she got "caught up" in routine work and did not adjust the medical records to reflect the fact that the medication was not given to those two patients.

5. On or about May 3, 2013 and August 12, 2013, Ms. Galgo-Rashid signed that she administered Hectorol 4 mcg. to patients A.F. and M.O., respectively. However, the inventory logs on those dates indicate that there was no Hectorol 4 mcg. available on May 3, 2013 and August 12, 2013.

CONCLUSIONS OF LAW

Respondent's documentation in medical records of administration of Hectorol at dates and times when they were not available at the facility constitutes engaging in misrepresentation in violation of N.J.S.A. 45:1-21(b).

DISCUSSION

Based on the foregoing findings and conclusions, a Provisional Order of Discipline seeking a reprimand, and completion of courses in nursing ethics and medication administration was entered on August 27, 2015. Copies were served upon Respondent via regular and certified mail. The Provisional Order was subject to finalization by the Board at 5:00 p.m. on the thirtieth day following entry unless Respondent requested a modification or dismissal of the stated findings of fact and conclusions of law by setting forth in writing any and all reasons why said findings and conclusions should be modified or dismissed and submitting any and all documents or other written evidence supporting Respondent's request for consideration and reasons therefor.

Respondent replied to the Provisional Order of Discipline and acknowledged that she had made a mistake in signing the flow sheets indicating that medication had been given when it had not been given. She maintains that this was the first time that she had done this and that she intended to correct the entries, but did not have time to do so. She argues that she merely made a mistake on one occasion. To the contrary, the Board finds Respondent charted that she had given medication that was not available to four different patients on three different days,

thereby displaying a pattern of behavior as opposed to a one time mistake.

Respondent also acknowledged that she had worked for the facility for one and half years and had told the Charge Nurse or Director of Nursing on multiple occasions that the facility needed this particular medication. As such, Respondent acknowledged that she knew the facility had an ongoing issue with keeping an adequate supply of this particular medicine. She maintained that it was not her responsibility to order the needed medications for the facility. However, the Board finds it was her responsibility, knowing that there were occasions when the medication was not available, to ensure that her documentation of administering the medication was accurate and that she did not chart that the medication was given on days when it was not available.

ACCORDINGLY, IT IS on this 29th day of January, 2016,

ORDERED that:

1. A reprimand is hereby imposed for the violation of N.J.S.A. 45:1-21(b).
2. Respondent shall, within three months of the filing of this Final Order of Discipline, provide documentation of successful completion of courses in 1) medication administration, and 2) nursing ethics. Respondent shall obtain approval from the Board of any courses she proposed to take to

satisfy this requirement. Pursuant to N.J.A.C. 13:37-5.3(i),
these course shall be in addition to the thirty hours of
continuing education required for biennial license renewal.

NEW JERSEY STATE BOARD OF NURSING

By: 
Patricia Murphy, PhD, APN
Board President