



on August 5, 2005. Respondent was licensed to practice professional nursing in the State of New Jersey on July 26, 1994; was licensed to practice professional nursing in the State of North Carolina on May 26, 1995; was licensed to practice professional nursing in the State of California on March 29, 2000; was licensed to practice professional nursing in the State of Pennsylvania on December 1, 2004, and was recognized by the Pennsylvania Board of Nursing as a Pediatric Critical Care Nurse Practitioner on May 12, 2008 with full prescriptive authority; was licensed to practice professional nursing in the State of Texas on February 23, 2006; and became Board recognized as a Pediatric Critical Care Nurse Practitioner in the State of Texas on March 2, 2006 with full prescriptive authority.

5. Respondent's professional nursing employment history includes:

|                   |                                     |  |
|-------------------|-------------------------------------|--|
| 05/1994 - 05/1995 | Child Home Care<br>Nurse Specialist | Saint Barnabas Medical Center<br>Livingston, New Jersey                |
| 06/1995 - 11/1996 | Registered Nurse                    | Durham Regional Hospital<br>Durham, North Carolina                     |
| 12/1996 - 11/1997 | Registered Nurse                    | Pitt County Memorial Hospital<br>Greenville, North Carolina            |
| 12/1997 - 01/2003 | Registered Nurse                    | Cross Country/Trav Corps<br>Boca Raton, Florida                        |
| 12/2002 - 07/2004 | Registered Nurse                    | North Carolina Baptist Medical Center<br>Winston-Salem, North Carolina |
| 03/2003 - 04/2004 | Instructor                          | Durham Technical Community<br>College, Durham, North Carolina          |
| 05/2004 - 07/2004 | Registered Nurse                    | National Healthcare Staffing<br>North Carolina                         |
| 08/2004 - 09/2005 | Instructor                          | University of Pennsylvania<br>Philadelphia, Pennsylvania               |
| 10/2005 - 02/2008 | PCCNP                               | Children's Medical Center of<br>Dallas, Dallas, Texas                  |
| 03/2007 - 06/2008 | PCCNP                               | Cook Children's<br>Fort Worth, Texas                                   |

6. Respondent has no prior disciplinary history with the Texas Board of Nursing.

7. At the time of the initial incident, Respondent was employed as a Pediatric Nurse Practitioner with Children's Medical Center of Dallas, Dallas, Texas, and had been in this position for one (1) year and one (1) month.
8. On or about November 28, 2006, while employed with Children's Medical Center of Dallas, Dallas, Texas, Respondent failed to immediately intubate Patient Medical Record Number 76890 before transporting the patient to have a computed tomography (CT) scan performed. The patient had signs of increasing intracranial pressure and could have experienced complications.
9. On or about December 24, 2006, while employed with Children's Medical Center of Dallas, Dallas, Texas, Respondent omitted corticosteroids from her admission orders for Patient Medical Record Number 1465236, who was admitted with an acute asthma exacerbation. Respondent's omissions could have caused the patient to experience complications.
10. On or about March 23, 2007, while employed with Children's Medical Center of Dallas, Dallas, Texas, Respondent failed to timely order antibiotics upon learning that Patient Medical Record Number 1291761 had an infection in his/her External Ventricular Drain (EVD). Respondent's omissions could have caused the patient to experience complications.
11. On or about April 5, 2007, while employed with Children's Medical Center of Dallas, Dallas, Texas, Respondent failed to appropriately manage the care of Patient Medical Record Number 764274, when Respondent treated the patient's metabolic acidosis as if it were respiratory acidosis by increasing the ventilator rate from twelve (12) to fourteen (14) respirations per minute. The patient suffered no adverse effects.
12. In response to the incidents in Findings of Fact Numbers Eight (8) through Eleven (11) Respondent states that the patient in paragraph Eight (8) with the intracranial pressure was immediately given additional treatments and medications (Manitol) to treat the signs of increased intracranial pressure. All treatments were approved by three (3) supervising physicians and the lack of intubation was not questioned until after the patient had been transported to the Head CT scan.

Respondent states that the corticosteroids were inadvertently omitted for the patient in paragraph Nine (9) from the admission orders. This was Respondent's first asthma admission. Respondent conferred with the supervising doctor and the facility's policies and procedures prior to submitting the admission orders for the patient. However, Respondent understands that corticosteroids should be listed on such admission orders and why her actions were incorrect, in retrospect.

Respondent states that she received the lab report at 8:50 a.m. indicating an infection was present for the patient in paragraph Ten (10) who had an External Ventricular Drain (EVD). Respondent maintained that she continued to assess the patient, then properly reported to rounds, which had already begun. The prescription for antibiotics was written during rounds

and Respondent is not accountable for the fact that the medication was not received from pharmacy or administered by the nurse until 11:30 a.m.

Respondent acknowledges that, for the patient in paragraph Eleven (11), she attempted to correct an acidotic blood gas by making a ventilator change which would lower the patient's CO2 level and raise his Ph. Respondent understood the differences between metabolic and respiratory acidosis, the proper treatment of each, and the complications from an improper diagnosis. The patient's Arterial Blood Gases (ABC'S) following her intervention actually improved.

13. Charges were filed on June 7, 2010.
14. Charges were mailed to Respondent on June 30, 2010.
15. The Board of Nursing does not and has never intended to revoke the Respondent's license to practice for these allegations. The Board's intention has only been to pursue a sanction of Warning with Stipulations. Respondent has instead opted to accept the below sanction of a Limited License with Stipulations.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received on Respondent's omissions is sufficient to prove violations of TEX. OCC. CODE §§ 301.452(b)(10)&(13) and 22 TEX. ADMIN. CODE §§ 217.11(1)(A), (B), (C), (G), (H), (M) & (T) and (4)(A) and 217.12(1)(A), (B) & (E) and (4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 725376, heretofore issued to DEBRA JEAN GLAAB, including revocation of Respondent's license to practice professionally nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT WILL receive the sanction of LIMITED LICENSE with Stipulations, and RESPONDENT WILL comply in all respects with the Nursing Practice Act, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order WILL be applicable to Respondent's nurse Licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse Licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) While under the terms of this Order, RESPONDENT WILL NOT provide direct patient care in Texas. For the purposes of this Order, direct patient care involves a personal relationship between the Nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

(2) SHOULD RESPONDENT desire to return to a clinical practice setting, which would require providing direct patient care in Texas, RESPONDENT WILL petition the Board for such approval.

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RESPONDENT'S CERTIFICATION

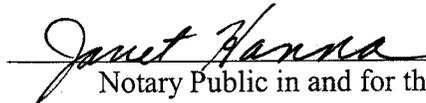
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 27 day of January, 2011.

  
DEBRA JEAN GLAAB, Respondent

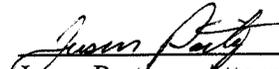
Sworn to and subscribed before me this 27th day of January, 2011.

SEAL

  
Notary Public in and for the State of JANET R. HANNA

**NOTARY PUBLIC OF NEW JERSEY**  
My Commission Expires July 17, 2011

Approved as to form and substance.

  
Jason Partney, Attorney for Respondent

Signed this 31 day of January, 2011

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 27th day of January, 2011, by DEBRA JEAN GLAAB, Registered Nurse License Number 725376, and said Order is final.

Effective this 8th day of February, 2011.



Katherine A. Thomas, MN, RN  
Executive Director on behalf  
of said Board