DOCKET NUMBER 507-10-1796

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 225647	**§**	**OF**
ISSUED TO	**§**	
LINDA JOY STOUT SAPP	**§**	**ADMINISTRATIVE HEARINGS**

TEXAS BOARD OF NURSING
I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

OPINION AND ORDER OF THE BOARD

TO: LINDA JOY STOUT SAPP
1607 WILD WOOD DRIVE
ROUND ROCK, TX 78681

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 27-28, 2011, the Texas Board of Nursing (Board) considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the registered nursing license of Linda Joy Stout Sapp without changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD, Staff's recommendations, and Respondent's presentation during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

IT IS, THEREFORE, ORDERED THAT Registered Nurse License Number 225647, previously issued to LINDA JOY STOUT SAPP, to practice nursing in Texas is hereby SUSPENDED and said suspension is ENFORCED until Respondent completes the following requirements:

(1) RESPONDENT shall undergo a mental health evaluation that meets the requirements specified by the Board. RESPONDENT shall cause the performing evaluator to send a report of the evaluation to the Board's office. The evaluation must state that the RESPONDENT is safe to return to the practice of nursing and must specify any recommended treatment or work restrictions.

(2) RESPONDENT shall pay an administrative reimbursement in the amount of two thousand dollars ($2,000). Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

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

IT IS FURTHER ORDERED that while Respondent's license is encumbered by this order, the 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 ORDERED that, upon successful completion of the above requirements, the Respondent shall be eligible to petition the Board to return to the practice of nursing. The Respondent shall be required to meet all Board regulations and policies in effect at that time. Further, should the Board grant the Respondent's petition to return to the practice of nursing, the Respondent shall be subject to all probationary

conditions set by the Board at that time.

Entered this 28th day of January, 2011.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-10-1796 (August 31, 2010).

SOAH DOCKET NO. 507-10-1796

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
	§	
PERMANENT CERTIFICATE	§	
NUMBER 225647	§	OF
	§	
ISSUED TO	§	
LINDA JOY SAPP	§	ADMINISTRATIVE HEARINGS

TABLE OF CONTENTS

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION 1

II. BACKGROUND 2

III. ALLEGATIONS AND APPLICABLE LAW 4

A. Charge I 4

1. Allegations 4
2. Applicable Law 5

B. Charge II 6

1. Allegations 6
2. Applicable Law 6

C. Respondent's Position 7

1. Charge I 7
2. Charge II 7

IV. EVIDENCE 8

A. Charge I 9

1. Patient 1 9
2. Patient 2 11
3. Patient 3 13
4. Meeting with Respondent and Leave of Absence 14
5. Assessment by David M. Tucker, Ph.D., ABPP-CN 15

B. Charge II 16

1. Respondent's request that Halloween decorations be removed 16
2. Respondent's treatment at Shoal Creek 16

C. Opinion of Matthew Ferrara, Ph.D., licensed psychologist 18

D. SANCTIONS 20

1. Charge I 20
2. Charge II 21
3. Costs 21

V. CLOSING ARGUMENT 22

A. Staff's Closing 22

B. Respondent's Closing Argument 22

VI. ANALYSIS AND RECOMMENDATION 23

VII. FINDINGS OF FACT 24

VIII. CONCLUSIONS OF LAW 26

SOAH DOCKET NO. 507-10-1796

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
	§	
PERMANENT CERTIFICATE NUMBER 225647	§	OF
	§	
ISSUED TO LINDA JOY SAPP	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Linda Joy Sapp (Respondent), a licensed registered nurse, for violating the Nursing Practice Act[1] and the Board's rules. The Administrative Law Judge (ALJ) finds that Staff met its burden of proof and agrees with Staff's request that Respondent's license be suspended until she presents the Board with an evaluation demonstrating her mental fitness to practice nursing. The ALJ agrees with Staff's position that Respondent's request to retire in lieu of suspension not be granted because, as a retiree *emeritus*, Respondent could work as an unpaid nurse and the public would not be protected. The ALJ also agrees with Staff's request that Respondent pay $2,000 in administrative costs for this case.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

Notice and jurisdiction are not contested and are addressed in the findings of fact and conclusions of law at the end of this Proposal for Decision.

On August 5, 2010, ALJ Sharon Cloninger convened the hearing on the merits at the State Office of Administrative Hearings, William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Assistant General Counsel R. Kyle Hensley represented Staff. Respondent appeared *pro se*. The hearing adjourned August 5, 2010. The

[1] TEX. OCC. CODE ANN. ch. 301.

record remained open until August 12, 2010, for Staff to present evidence of administrative costs.

II. BACKGROUND

The following facts are undisputed. Respondent, who has been a registered nurse for 39 years, holds Permanent Certificate Number 225647 issued by the Board.[2] She worked as a staff nurse at Seton Medical Center (Seton) in Austin, Texas, for 18 years prior to her termination from employment in 2007. She currently cares for her mother full-time and is not employed as a nurse.

Respondent's termination from Seton followed psychiatric treatment at Shoal Creek Hospital (Shoal Creek) in Austin, Texas, in October 2006. A condition of her return to work at Seton was that she participate in the Texas Peer Assistance Program for Nurses (TPAPN) to ensure patient and staff safety.[3] Respondent's TPAPN agreement required her to meet with her direct supervisor and to be monitored by a nurse of her choice while on duty. Respondent was also placed on a performance improvement plan which required her to consult with a monitoring nurse before she could call a physician or critical response team for one of her assigned patients.

After she returned to work, Respondent engaged in confrontational behavior with Seton staff—including her monitor—over patient care on three occasions in January and February 2007. In addition, Staff contends Respondent overstepped her role as a nurse by attempting to diagnose two of the patients involved. As a result of this behavior and signs of mental illness such as assertions that co-workers were "out to get her" and her inability to make clear decisions, Respondent was placed on a leave of absence from February 11 to June 11, 2007,[4] and eventually terminated from employment.

---

[2] Staff Exh. 1.

[3] The Return to Work Agreement was signed December 15, 2006, by Respondent and her supervisors Heather Hill and Tiffany Thornton. Staff Exh. 2.

[4] Staff Exh. 7 at 1-2.

Staff has filed two formal charges against Respondent[5] related to her confrontational behavior and mental health condition. In general, Staff alleges that Respondent engaged in unprofessional conduct that is likely to injure a patient; displayed lack of fitness to practice because of a mental health condition; and failed to conform to the minimum standards of acceptable nursing practice.

On June 10, 2010, Staff required Respondent to submit to an evaluation as allowed under TEX. OCC. CODE ANN. § 301.4521(b)(2)[6] to determine whether her suspected mental impairment prevents her from practicing nursing with reasonable skill and safety.[7] Respondent did not undergo the requested evaluation. The request was based on information received by Staff that:

- Respondent had a psychotic episode in October 2006 which required admission to Shoal Creek Hospital;
- from January 13, 2007, and forward, Respondent lacked fitness to safely provide care due to memory and decision-making problems; and
- a neurological examination conducted June 27, 2007, showed Respondent has difficulty with rapid assimilation of verbal information and comprehension, which could affect Respondent's ability to recognize subtle signs, symptoms, or changes in patients' conditions, and Respondent's ability to make rational, accurate, and appropriate assessments, judgments and decisions regarding patient care, thereby placing patients in potential danger.

Staff recommends that Respondent's license be suspended until an evaluation shows her mental health has been restored and she is fit to practice nursing.

---

[5] Formal Charges were filed July 22, 2009. Staff Exh. 3. First Amended Formal Charges were filed March 23, 2010. Staff Exh. 3a.

6 The Board may require a nurse to submit to an evaluation only if the Board has probable cause to believe that the nurse is unable to practice nursing with reasonable skill and safety to patients because of mental impairment.

[7] Staff Exh. 4a.

III. ALLEGATIONS AND APPLICABLE LAW

The following allegations are contained in the hearing notice issued December 17, 2009:[8]

A. Charge I

1. Allegations

Staff alleges that from October 14, 2006, through February 11, 2007, while employed with Seton Medical Center in Austin, Texas, Respondent exhibited behavior that was disruptive and inappropriate while on duty, which may have resulted in emotional harm to patients, in that:

a. On January 13, 2007, Respondent inappropriately and inaccurately "diagnosed" that Patient MR # 296176 (Patient 1) was in congestive heart failure when an assessment by a physician and subsequent laboratory tests revealed the patient was not in acute congestive heart failure. Furthermore, Respondent's nurse's notes for this patient did not contain an appropriate nursing assessment but contained a diagnosis and plan of care for the patient;

b. Respondent inappropriately and inaccurately "diagnosed" that Patient MR #295180 (Patient 2) was "in trouble" and stated she was going to call the Critical Response Team. Although the patient was assessed and determined not to be in distress, Respondent continued to state the patient was in bad shape and needed a higher level of care. Furthermore, Respondent's nurse's notes did not contain an appropriate nursing assessment in that she documented a review of the lab results and the plan was to "open the airway, stabilize, and blow off CO2...Guarded condition" which was contradictory to the physician's progress notes that did not indicate the patient's condition was guarded;[9] and

c. Respondent insisted that the cast on Patient MR #755166 (Patient 3) was too tight. The patient had undergone a right below-the-knee amputation with a cast on the stump to help placement of a

[8] Staff Exh. 4.

[9] The specific date of the incident is not alleged in the hearing notice. The evidence established the incident occurred February 4, 2007.

> prosthetic fitting. Although the cast was examined and determined not to be too tight, Respondent continued to insist the cast was too tight.[10]

2. Applicable Law

Staff states that Respondent's failure to promote a safe environment that may have resulted in emotional harm to patients constitutes grounds for disciplinary action in accordance with TEX. OCC. CODE ANN. §§ 301.452(b)(10) and (13), and is a violation of 22 TEX. ADMIN. CODE (TAC) §§ 217.11(1)(B) and 217.12(6)(C).

Under TEX. OCC. CODE ANN. §§ 301.452(b)(10) and (13), a person is subject to disciplinary action by the Board for:

> (10) unprofessional or dishonorable conduct that, in the [B]oard's opinion, is likely to deceive, defraud, or injure a patient or the public; or. . .
>
> (13) failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the [B]oard's opinion, exposes a patient or other person unnecessarily to risk of harm.

Pursuant to 22 TAC §§ 217.11(1)(B) and 217.12(6)(C), all registered nurses shall implement measures to promote a safe environment for clients and others, and may not cause or permit physical, emotional, or verbal abuse or injury or neglect to the client or the public. Actual injury to a client need not be established.

---

[10] The specific date of this alleged incident is not included in the hearing notice. The evidence established the incident occurred February 11, 2007.

B. Charge II

1. Allegations

Staff alleges that while employed at Seton Medical Center in Austin, Texas, Respondent may have lacked fitness to safely practice in that she expressed religious grandiosity as exemplified by the following behavior:

> **a.** Respondent demanded that the Halloween decorations be removed [from Seton] because "God has spoken to her and the decorations were devil worship."
>
> **b.** Respondent was involuntarily admitted to Shoal Creek Hospital on October 22, 2006, under emergency detention due to her exhibiting religious grandiosity, which included anointing herself and her son with oil for protection from demon forces and then attempting to start a fire to burn a Japanese kimono, which had a dragon on the back. While in-patient, Respondent refused to take any medications and was discharged against medical advice on October 27, 2006, with a diagnosis of AXIS 1—Schizoaffective disorder, bipolar type.

2. Applicable Law

Staff states that the above behavior constitutes grounds for disciplinary action in accordance with TEX. OCC. CODE ANN. §§ 301.452(b)(10), (12), and (13),[11] and is a violation of 22 TAC §§ 217.11(1)(T) and 217.12(5).

As set out in TEX. OCC. CODE ANN. §§ 301.452(b)(12), a person is subject to disciplinary action for lack of fitness to practice because of a mental health condition that could result in injury to a patient or the public

[11] The language of TEX. OCC. CODE ANN. §§ 301.452(b)(10) and (13) is included in the section of the Proposal for Decision related to Charge I.

Under 22 TAC § 217.11(1)(T), a nurse may accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's emotional ability.

Pursuant to 22 TAC § 217.12(5), the inability to practice safely is defined in relevant part as a demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of any mental condition.

C. Respondent's Position

1. Charge I

Respondent disagrees that her behavior was inappropriate or her "diagnoses" inaccurate. She insists she acted professionally and that her behavior was necessary to ensure proper care of the patients assigned to her. She asserts that her persistence in seeking treatment for Patient 1 saved that patient's life.[12]

2. Charge II

Respondent defends her request for removal of the Halloween decorations because, she explains, they were not in keeping with the Christian mission of Seton, the spider webs hindered access to the tube transport system and Omnicell dispensing machine, and a battery-operated spider frightened elderly patients who were trying to do post-op ambulation.[13]

Respondent also defends her attempt to burn her son's kimono as necessary to protect her household from the kimono's demonic presence.[14]

---

[12] Respondent's testimony. *See also* Staff Exh. 5, at 243-245, Staff Exh. 5C at 2, Staff Exh. 5E, and, in general, Respondent's correspondence with the Board, Staff Exh. 5, at 1-257.

[13] Respondent's testimony. *See also* Staff Exh. 5, at 4, 121, and 246.

[14] Respondent's testimony. *See also* Staff Exh. 5, at 247.

Respondent points out that after five days of observation at Shoal Creek, she was released to work under TPAPN and that she was not on medication when she was discharged.[15] She claims she was not discharged against medical advice but rather with the approval of her psychiatrist, Sean Howell, M.D.[16] She states the Shoal Creek diagnosis of AXIS 1—Schizoaffective disorder, bipolar type[17] was incorrect, but provided no evidence to support her contention. She noted that Dr. Howell found her fit to return to work effective December 4, 2006.[18]

IV. EVIDENCE

Staff presented the expert testimony of Matthew Ferrara, Ph.D., a licensed psychologist, and Bonnie Cone, RN, MSN, a Nursing Consultant for Practice with the Board; and the testimony of three nurses who worked with Respondent and are currently employed by Seton: Angela Staubaum, Chief Nursing Officer, who worked with Respondent as a staff nurse and was Respondent's Director of Nursing in October 2006; Heather Hill, RN, Clinical Manager, who managed Respondent on the dates in question; and Tiffany Thornton, RN, Clinical Manager, who also managed Respondent on the dates of the alleged incidents. Staff also called Respondent as a witness and introduced documentary evidence.

Respondent testified on her own behalf and introduced no documentary evidence.

---

[15] Respondent's testimony. *See also* Staff Exh. 5, at 4 and 247. But Respondent's Shoal Creek medical records show she refused medication while a patient and was prescribed medication upon her release. Staff Exh. 6 at 11, 17, and 47-56.

[16] Respondent's medical records from Shoal Creek do not support this statement. Staff Exh. 6 at 11.

[17] Staff Exh. 6 at 11, 17, and 47.

[18] Respondent's testimony. *See also* Staff Exh. 5E at 2 and Staff Exh. 5F at 20.

A. Charge I[19]

Ms. Hill described Seton's fifth floor, where Respondent worked, as an acute care unit with 64 beds. She said the beds were typically full or nearly full with a patient turnover rate of 40 percent daily. She testified that each nurse is usually assigned five or six patients per shift. Nurses on the fifth floor must be able to multi-task, react quickly, anticipate patients' needs, and be team players, she said.

All three nurse witnesses testified that prior to October 2006, Respondent was very thorough with patients, very conscientious, and ensured patients had what they needed.[20] But they all observed changes in Respondent after her stay at Shoal Creek. Ms. Staubaum said Respondent became hyper-vigilant, that is, too focused on one aspect of a single patient to the potential detriment of her other assigned patients. She became confrontational with staff on the three alleged occasions when they disagreed with her proposed patient care. When counseled about her behavior, Respondent insisted her concerns about the three patients were correct and that Seton staff were out to get her. All three nurse witnesses testified they would not re-hire Respondent because they do not trust her judgment.

1. Patient 1

Patient 1 was a 90-year-old woman admitted with bronchitis.[21] Ms. Thornton testified that on January 13, 2007, Respondent inaccurately determined Patient 1 was in acute cardiac distress and "diagnosed" Patient 1 to have congestive heart failure. At Respondent's insistence, the charge nurse agreed a physician could be called. The physician found Patient 1 was not in distress.

---

[19] Staff also presented evidence about an October 2006 incident involving Respondent and a respiratory therapist. But this incident was not alleged in the hearing notice. Therefore, the ALJ finds the evidence related to the October 2006 incident to be irrelevant to this proceeding.

[20] *See also* letters of recommendation. Staff Exh. 5F at 37-43.

[21] Staff Exh. 8 at 3.

Respondent claims that due to her early assessment of Patient 1's condition, Patient 1 was kept from worsening congestive heart failure.[22] Respondent testified that she saved Patient 1's life.

Ms. Hill testified that in her notes and words, Respondent used a diagnosis and patient plan like a physician would, overstepping her duties as a nurse. Specifically, Respondent's nurse's notes state "P:lungs A: few persistive crackles, dry cough. Plan of care I: assess cardiac function and ejection fraction with cardiac echo, accurate I/O, initiate ASA, micardis for B/PO2 PRN, PT to strengthen, fall precautions (family at bedside)."[23] Ms. Thornton said it would have been within Respondent's role as a nurse to report Patient 1's vital signs and conditions such as edema, but not to diagnose Patient 1.

Ms. Staubaum explained that only a physician or nurse practitioner may make a medical diagnosis. A nursing diagnosis is different: the nurse records her observations of a patient without arriving at a medical diagnosis. Ms. Staubaum testified that Respondent's attempt to medically diagnose Patient 1 and later, Patient 2, posed a potential danger to those patients because Respondent could have decided to administer treatment on her own without a physician's orders.

According to the record,[24] at one point Respondent called the charge nurse stating in a very rushed, anxious tone that Patient 1 was in congestive heart failure and asked to call a physician. The charge nurse found Patient 1 walking back to her bed from the bathroom; Patient 1 said she felt "okay." The charge nurse did not feel Patient 1 was in distress and did not agree to call a physician, but did have a respiratory therapist assess her condition. During the assessment, Respondent continued to be very anxious. Respondent's state of alarm caused other staff to rush into the room to find out if help were needed. The charge nurse finally agreed that Respondent could call a physician, but reminded her she could only state her nursing assessment

[22] Staff Exh. 5F at 11 and Staff Exh. 8 at 10.

[23] Staff Exh. 8 at 3-4.

[24] Staff Exh. 8 at 3.

to the physician and not a medical diagnosis. The physician ordered tests that indicated Patient 1 was not in acute congestive heart failure.

Ms. Hill said a nurse may act as a patient's advocate, but in this instance, Respondent was frantic, not calm, in her insistence that Patient 1 needed to be seen by a physician due to acute cardiac distress.

On cross, Ms. Staubaum agreed with Respondent that it was appropriate for her to request that a physician be called. But she said it was not appropriate for Respondent to continue to push to have Patient 1 taken to critical care after the physician's determined the patient was not in distress.

Ms. Thornton said she, Ms. Hill, and Ms. Staubaum met with Respondent on February 6, 2007, to discuss the incident. According to Ms. Thornton, Respondent insisted she had behaved appropriately and stated other people knew she was working under a TPAPN contract and were trying to get her in trouble. But Respondent had been told that her TPAPN contract was confidential, known only to Ms. Thornton, Ms. Hill, and Ms. Staubaum, unless Respondent chose to disclose she was under TPAPN, Ms. Thornton said.

2. Patient 2

The record shows[25] that at 11 p.m. on February 4, 2007, at the end of her shift, Respondent was assigned to admit Patient 2. The charge nurse reported that she and the night nurse were exchanging reports when they overheard Respondent say to nobody in particular that Patient 2 was "in trouble" and she was going to call the critical response team. The usual practice is for a staff nurse to consult with a charge nurse before calling the critical response team. The evening charge nurse went into Patient 2's room and found him receiving treatment from the respiratory therapist, whose assessment showed Patient 2 was not in distress. Patient 2 was in no visible distress, his color was good, and he told the evening charge nurse he felt fine.

[25] Staff Exh. 8 at 6.

The evening charge nurse and respiratory therapist agreed Patient 2's condition was stable. But Respondent argued with the respiratory therapist, stating, "He's retaining CO2. He is in bad shape. He needs a higher level of care." She repeated these statements over and over until the respiratory therapist left the floor. She continued to obsess over Patient 2, so the evening charge nurse asked Respondent to make an admission note and go home since her shift was over.

Respondent's nurse's notes for Patient 2 state his condition is "[g]uarded," when the physician's progress notes do not indicate a guarded condition. The nurse's notes are not appropriate for a nursing assessment.[26]

In a letter to the Board, Respondent reiterated her ongoing belief that Patient 2 was too ill for night shift staffing. She complained in the letter that when she tried to call the critical response team, she was stopped at the telephone by "Patricia and Sara as well as the oncoming 11-7 staff."[27]

Ms. Staubaum testified that Respondent was not appropriate at any time with Patient 2. Respondent wanted to call the critical response team, even though the physician had noted Patient 2's condition to be "stable" and Patient 2's daughter, who is a registered nurse, stayed with him. Respondent's monitor did not agree with her that the critical response team was needed, but Respondent did not listen. The monitor reported to Ms. Staubaum that Patient 2's daughter told her she was uncomfortable with Respondent, as was Patient 2.

Ms. Hill said Respondent did not work as a team member for Patient 2's care. She said Respondent stayed at the hospital after her shift was over, exhibiting too much concern for Patient 2. Ms. Hill further explained that Respondent violated her TPAPN contract and Return to Work Agreement when she did not abide by the monitor's decision not to call the critical response team but instead continued to argue her position.

---

[26] Staff Exh. 8 at 6. The author of this exhibit is not identified.

[27] Staff Exh. 5F at 12. Patricia and Sara are not further identified in the record.

The ALJ notes that on February 5, 2007, the day after the incident regarding Patient 2, Dr. Howell prepared a TPAPN Progress Report that stated Respondent was "[d]oing well from a psychiatry standpoint. Not taking any meds. No signs/symptoms of relapse."[28] There is no evidence in the record to show whether Dr. Howell was aware Respondent's behavior regarding Patient 2.

3. Patient 3

The record shows that on February 11, 2007, Respondent was assigned to Patient 3, who had a right below-the-knee amputation two days before, with cast placement on the stump to help shape for a later prosthetic fitting. Respondent, concerned that the cast was too tight, called the charge nurse and wanted to call the emergency room to have the cast removed. The charge nurse did not find the cast to be too tight but suggested that the Orthopedic Unit charge nurse should render a second opinion. The Orthopedic Unit charge nurse also determined the cast was not too tight. Respondent did not agree and continued to insist that a physician be called. The Orthopedic Unit charge nurse finally walked away after the conversation was repeated several times. Respondent asked the fifth floor charge nurse several more times if a physician could be called. A physician was not called and Patient 3 had no negative outcomes related to the cast or circulation.[29]

Ms. Staubaum testified that her concern about the situation was Respondent's continuing argument with both nurses after the Orthopedic Unit charge nurse determined the cast did not need to be adjusted. Ms. Hill said the disruptive disagreement put Seton in a bad light for patients and people in the hallways who overheard the dispute. Ms. Hill said the behavior was out of the ordinary for Respondent and concerned her at the time.

---

[28] Staff Exh. 5I at 4.

[29] Staff Exh. 8 at 7.

In a letter to the Board,[30] Respondent listed the medical reasons why she believed a physician should have been called after the Orthopedic Unit charge nurse determined Patient 3's cast was not tight enough to be split, as suggested by Respondent. Mainly, she was concerned that Patient 3, who was a dialysis patient, exhibited increasing thigh edema. She stated a physician should be called for any assessment which is not within normal limits. She concluded, "Would you rather be taken care of by someone who cares about your cast and safety or by someone who does not care?"

4. Meeting with Respondent and Leave of Absence

Ms. Staubaum testified that she met with Respondent regarding the incidents related to the three patients. The focus of the meeting was for Respondent to stop advocating for additional treatment after a higher-up nurse determined the requested treatment was unnecessary, Ms. Staubaum said. Respondent did not listen to Ms. Staubaum's concerns, but insisted she was right about the patients' needs even though nothing she had predicted happened with the three patients, Ms. Staubaum continued. According to Ms. Staubaum, Respondent also accused the nurse monitors of being out to get her. Ms. Staubaum said she felt Respondent did not have the judgment necessary to safely be with patients.

Ms. Hill testified that Respondent was placed on a leave of absence because her supervisors were not confident she could provide safe care to patients and might even endanger them. On cross-examination, Ms. Hill explained that Respondent's behavior "was very scary to us," and that she was concerned about Respondent's mental state. In response to a question by Respondent, Ms. Hill assured her that the decision to place her on a leave of absence was made after a thorough review of all the facts.

[30] Staff Exh. 5F at 13 and Staff Exh. 8 at 9.

5. Assessment by David M. Tucker, Ph.D., ABPP-CN

On four occasions between May 17 and June 27, 2007, Respondent was seen for a neuropsychological evaluation by David M. Tucker, Ph.D., ABPP-CN.[31] Respondent testified that she asked Dr. Tucker to evaluate her current condition without considering her past mental health history. She did not inform him of an approximately 30-day stay at Austin State Hospital around 1999 and did not provide him with her Shoal Creek medical records.

In his June 29, 2007 report,[32] Dr. Tucker concluded Respondent "is likely capable to complete most functions as a nurse." He recommended a supervised work trial. He recognized that Respondent was likely to have difficulty with rapid assimilation of verbal information and recommended against work settings such as the emergency department and operating rooms. He said verbal instructions need to be presented to Respondent at a fairly slow rate to ensure full comprehension. He found Respondent has reduced reading comprehension.

Ms. Staubaum explained that Dr. Tucker's finding that Respondent is unable to rapidly assimilate verbal information would prevent her from working with physicians who give oral instructions. She said Dr. Tucker's recommendation that Respondent not work in an emergency room situation would also apply to Respondent's position on the medical/surgical unit at Seton, because the fifth floor nurses handle what, in the past, was considered to be critical care, due to the increase in the complexity of patient care.

At hearing, Respondent minimized Dr. Tucker's findings. She claimed that Dr. Tucker based his conclusion about her memory on a "dumb little test" that she could not pass because she was tired. She testified she did not do well on the reading comprehension test because the subject matter bored her and she was "cheated out of 15 minutes of time."

---

[31] Staff Exh. 5I at 10-17.

[32] Staff Exh. 5I at 10-17.

B. Charge II

1. Respondent's request that Halloween decorations be removed

Ms. Thornton described the Halloween decorations as pumpkins, skeletons, bowls of candy, and spiders, "nothing bloody or graphic." She said Respondent complained to the house supervisor on October 24, 2006, that the decorations were "evil," and demanded that they be taken down.[33] Ms. Thornton said the same decorations had been used in previous years, but this was the first time Respondent complained. Ms. Hill saved Respondent's voice message and played it for Ms. Staubaum. Ms. Staubaum testified this was not how Respondent typically talked. Ms. Hill found the change in Respondent to be "troubling." The decorations were not taken down.

Respondent testified she complained about the Halloween decorations because they were outside Seton's Christian philosophy and the webs covering the telephone and work station were a hindrance to work. She denied saying the decorations were "devil worship" or that "God had spoken to her," as alleged by Staff. She described Halloween as an occult observation that contradicts Seton's values of honoring the Lord Jesus. She also noted that some of the older patients were afraid of a battery-operated spider that was part of the Halloween decorations.

2. Respondent's treatment at Shoal Creek

On October 22, 2006, Respondent anointed her son with olive oil while he was asleep and took the kimono given to him by his Japanese girlfriend from his room to burn it. Her husband called the police and had her taken to Shoal Creek as a danger to herself and others. Upon her arrival at Shoal Creek, she voluntarily signed in.[34]

---

[33] On October 24, 2006, Respondent was a patient at Shoal Creek.

[34] Staff Exh. 6 at 157.

Respondent testified she tried to burn the kimono even though she knew her son would be angry. She said her son did not realize the dragon on the kimono represented Satan.

Respondent testified that "getting rid of the kimono was like trying to kill a snake." She said demons are real and the kimono was endangering everyone in the house. There being no burn ban she placed the kimono outside in a bucket, doused it with olive oil—which she said represents the Holy Spirit—and tried to light it. But the garment would not burn. She said she managed to poke a hole in the dragon's mouth, thus breaking the kimono's demonic power, and she felt at peace.

Respondent admitted that while she was at Shoal Creek, she refused to take the Abilify prescribed to her. She said Abilify is a psychotropic drug used to treat anxiety, delusions, and hallucinations. She testified that she did not take the Abilify because she feared it would endanger her health and possibly lead to brain damage.[35]

Respondent testified she is not currently on prescription medication and has not been for years. She stated she was prescribed psychotropic medication following her approximately 30-day stay at Austin State Hospital 10 years ago due to a breakdown over her sister's death, but weaned herself off the medication. As far as her mental health is concerned, she also recalled suffering from post-partum depression following the birth of her son in 1986, but could not remember if she was hospitalized as a result.

Ms. Thornton testified that before the October 2006 psychotic break, Respondent was a very conscientious nurse who used advanced nursing skills, focused on patient care, and exhibited no signs of mental health issues. Ms. Thornton related that on either October 25 or October 26, 2006, Respondent telephoned her to report she had been admitted to Shoal Creek and was refusing medication. Ms. Thornton described Respondent's conversation as "scattered" and "out of chronological order."

---

[35] *See also* Shoal Creek Discharge Summary. Staff Exh. 6 at 10-11.

Ms. Thornton testified that when Respondent returned to work, she was hyper-vigilant. While a nurse may advocate on a patient's behalf, she may not diagnose a patient's condition, as Respondent did, Ms. Thornton explained. In the three situations at issue, the patients were not in danger due to Respondent's hyper-vigilance, but they could have been if Respondent had performed the interventions she believed were necessary without a physician's orders, Ms. Thornton concluded.

Ms. Thornton said paranoid behavior, such as Respondent's belief that someone is out to get her, puts patients' safety at risk. Nurses need to think clearly and be focused on patient care, she said.

Ms. Thornton testified that after Respondent returned to work from her stay at Shoal Creek, it became difficult to converse with her because she would not stay on topic. Ms. Thornton said Respondent required redirection, which could endanger patients. According to Ms. Thornton, Respondent's inability to focus and her difficulty with the rapid assimilation of verbal information as identified by Dr. Tucker would be problematic if she were to confer with a physician over the telephone, for instance. For these reasons, Ms. Thornton would not rehire Respondent, she said.

C. Opinion of Matthew Ferrara, Ph.D., licensed psychologist

In Dr. Ferrara's opinion, Respondent cannot work safely as a nurse because she suffers from paranoia and has an undiagnosed, untreated mental disorder that dates back to at least 2006. He based his opinion on Respondent's testimony at hearing and a review of Respondent's mental health records, Seton medical records regarding the three patients, and correspondence between Respondent and Staff.

Dr. Ferrara said a paranoid person such as Respondent assigns her own meaning to what another person says. As an example, he used Respondent's testimony in response to the question, "Were you admitted to Shoal Creek Hospital?" Her reply was, "You can't believe the abuse I was under by Mr. Sapp." In Dr. Ferrara's opinion, if Respondent were to work as a

nurse, she would demonstrate the same difficulty listening to patients as she did at the hearing in her communication with Staff, witnesses, and the ALJ. Her paranoia would interfere with gathering information from patients and objectively communicating with physicians and nurses, he said.

The signs of paranoia that Dr. Ferrara found in the documents he reviewed and the nurses' testimony were Respondent's hyper-vigilance with patients; her assertion that others were out to get her; her inability to be self-critical; her blaming others for her problems; her tendency to go off on tangents, responding to her interpretation of what someone meant; her inability to understand the big picture due to getting lost in the details; and her grandiosity in asserting that she knows more than other nurses, putting herself in the role of a priest in her attempt to exorcise the kimono, and putting herself in the role of a physician by diagnosing patients.

Respondent's testimony defending her attempt to burn the kimono troubled Dr. Ferrara because she justified her action using the same rationale she did in 2006, without having moved on from the incident. Even taking into account Respondent's strong Christian faith, Dr. Ferrara found her defense to be based on an irrational explanation about the relief she felt after burning a hole in the dragon's mouth and that Satan and demons are real.

Dr. Ferrara expressed concern that Respondent did not tell Dr. Tucker about her previous mental health history at the time of her neuropsychological evaluation. He said the incomplete history prevented Dr. Tucker from being able to understand how Respondent functioned. Respondent's reduced reading comprehension noted in Dr. Tucker's report is due to her paranoid filter that limits input, a condition that would interfere with patient care, Dr. Ferrara said. The finding that verbal instructions need to be given slowly to Respondent impairs her ability to work as a nurse in any department at Seton, Dr. Ferrara said.

D. Sanctions

Ms. Cone, a Nursing Consultant for Practice with the Board, testified that she reviewed Respondent's licensure records, Staff's formal charges and amended charges, and Respondent's responses. She recommended suspension of Respondent's license until a full psychiatric evaluation demonstrates Respondent's mental health has been restored. She explained that the retired *emeritus* status requested by Respondent in lieu of suspension would not protect the public. As a retiree *emeritus*, Respondent would be eligible to provide unpaid nursing care to patients and she has not shown her fitness to practice nursing, Ms. Cone said.

1. Charge I

Ms. Cone testified that under the Board's Disciplinary Matrix,[36] Respondent's unprofessional conduct alleged in Charge I is a Second Tier Offense, because her violation of TEX. OCC. CODE ANN. § 301.452(b)(10) was not isolated but occurred with Patient 1, Patient 2, and Patient 3 in January and February 2007. Ms. Cone recommended Sanction Level II—which includes license suspension—for Respondent's unprofessional conduct due to the aggravating circumstances of the number of events and patient vulnerability. Ms. Cone found no mitigating factors to consider in her recommendation regarding Charge I.

Ms. Cone explained that nurses are supposed to collaborate with other health care professionals but, on the occasions in question, Respondent was confrontational with Seton staff, was argumentative with her assigned monitor, stepped outside her role as a registered nurse in her attempt to diagnose patients on her own and, at the hearing, continued to deny her behavior was unprofessional.

Ms. Cone expressed concern about Respondent's tunnel vision regarding care of specific patients, which was potentially detrimental to Respondent's ability to care for her other assigned

[36] Staff Exhibit 15. The Board's Disciplinary Matrix is found at 22 TAC § 213.33(b).

patients. She noted that actual physical or emotional injury to a client need not be established for a nurse to violate 22 TAC § 217.12(6)(C).

2. Charge II

Ms. Cone found a Second Tier Violation of TEX. OCC. CODE ANN. § 305.452(b)(12), which subjects a person to disciplinary action for lack of fitness to practice because of a mental health condition that could result in injury to a patient or the public. She recommended Sanction Level II because Respondent's mental illness remains untreated. She noted that Dr. Ferrara confirmed Respondent suffers from paranoia and an undiagnosed, untreated mental health condition. Under Sanction Level II, the Board may suspend a license until the individual is able to provide evidence of competency.

Ms. Cone found a Second Tier Violation of § 301.452(b)(13) due to Respondent's failure to conform to minimum standards[37] of acceptable nursing practice, including Respondent's attempt to diagnose and over treat patients. She was concerned about Respondent's ongoing denial that she had acted inappropriately in her care of patients. She recommended Sanction Level II, which permits suspension of a nurse's license.

3. Costs

Pursuant to TEX. OCC. CODE ANN. § 301.461, the Board seeks to recover $2,000 in administrative costs for the proceeding. The $2,000 is for services rendered by the Board's expert witness, Dr. Ferrara.

---

[37] 22 TAC § 217.11.

V. CLOSING ARGUMENT

A. Staff's Closing

Mr. Hensley recognized Respondent's experience as a nurse prior to her mental health condition, but said the Board must protect the safety of the public. He referred to Respondent's psychotic breaks about 10 years ago and in 2006, and Dr. Ferrara's opinion that Respondent is paranoid and not mentally fit to practice nursing at this time. He recommended that Respondent's license be suspended until she presents the Board with a forensic psychological evaluation showing her mental health has been restored. He said the Board would not pay for the evaluation, but could provide Respondent with an approved list of providers or consider a provider of Respondent's choice.

B. Respondent's Closing Argument

Respondent argued that her successful employment with Central Texas Rehab after her termination at Seton is evidence of her fitness to continue working as a registered nurse.[38] She said she is currently uninsured and does not have the financial resources to obtain a mental health evaluation as requested by Staff. She said she would like to become a retiree *emeritus* to remain eligible for continuing education classes because she likes to stay current. She pointed out that should she be permitted to retire, caring for her mother allows her no extra time to work as an unpaid nurse.

Respondent argued that she gave her patients good care. She criticized her supervisors for finding it more important to write her up than to consider her nursing skills. She claimed her nursing skills were superior to those of her nurse monitors. She averred that her TPAPN contract caused her to work under a stigma that risked her patients' lives. She said she does not have a problem with communication; the problem instead is that nobody else listened to her patients' needs.

[38] She stopped working at Central Texas Rehab in 2008 to become her mother's full-time caregiver.

VI. ANALYSIS AND RECOMMENDATION

After weighing the evidence, the ALJ finds Staff has met its burden of proving that on three occasions Respondent exhibited unprofessional conduct likely to injure a patient or the public and that Respondent lacks the fitness to practice nursing at this time due to her mental condition.

First, the ALJ notes that, for the Board to have a ground for disciplinary action pursuant to TEX. OCC. CODE ANN. § 301.452(10), the Board is required to find that the nurse's conduct is not only "unprofessional" but also "likely to . . . injure a patient or the public." Clearly it was unprofessional for Respondent to overstep her role as a registered nurse and include her own diagnoses of patients' conditions in their charts and to continue to argue with her monitor, a charge nurse, and a respiratory therapist when she disagreed with their determinations. Testimony established that while Respondent's unprofessional behavior did not result in physical injury on the three occasions in question, there is a legitimate concern that Respondent could have imposed her own treatment on the patients without a physician's orders.

The ALJ finds that the preponderance of the evidence supports Staff's second ground for seeking disciplinary action, that Respondent lacks fitness to practice because of a mental condition that could result in injury to a patient or the public. Dr. Ferrara testified that Respondent suffers from paranoia and an undiagnosed, untreated mental illness that has been ongoing since at least 2006. No evidence contradicted Dr. Ferrara's opinion.

Based on the discussion above, the ALJ finds that Staff met its burden of proving that Respondent's license should be suspended for the following: (1) unprofessional conduct that is likely to injure a patient; (2) failure to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient unnecessarily to the risk of harm; and (3) lack of fitness to practice because of a mental condition that could result in injury

to a patient.[39] According to Ms. Cone, the proper sanction is suspension of Respondent's license until she can demonstrate to the Board that she is mentally competent to practice nursing. For this reason, the ALJ recommends that Respondent's nursing license be suspended until she provides the Board with a psychological evaluation demonstrating her fitness to practice.

VII. FINDINGS OF FACT

1. Linda Joy Sapp (Respondent), a registered nurse licensed by the State of Texas, holds permanent certificate number 225647.

2. Staff (Staff) of the Texas Board of Nursing (Board) filed its formal charges against Respondent on July 22, 2009, on the grounds that Respondent failed to promote a safe environment that may have resulted in emotional harm to patients; engaged in unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient or the public; displayed lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public; and failed to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient or other person unnecessarily to risk of harm.

3. On December 17, 2009, Staff mailed a copy of its notice of hearing and formal charges to Respondent by certified mail, return receipt requested.

4. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

5. A hearing on the merits was convened on August 5, 2010, before Administrative Law Judge Sharon Cloninger. Assistant General Counsel R. Kyle Hensley represented Staff. Respondent appeared pro se. The record closed August 12, 2010, after Staff submitted evidence of administrative costs for reimbursement.

6. Respondent worked as a staff nurse at Seton Hospital (Seton) in Austin, Texas, for 18 years prior to her termination from employment in 2007.

7. Respondent is currently her mother's full-time caregiver and is not working as a nurse.

[39] The ALJ finds the evidence does not support the allegation that Respondent violated 22 TAC § 217.11(1)(T), related to a nurse accepting only nursing assignments commensurate with the nurse's emotional ability.

8. Respondent's termination from Seton followed five days of psychiatric treatment at Shoal Creek Hospital (Shoal Creek) in Austin, Texas, in October 2006.

9. Respondent was admitted to Shoal Creek on October 22, 2006, after she attempted to burn a kimono that belonged to her son, claiming the garment was possessed by demons and a danger to her household.

10. While a patient at Shoal Creek, Respondent refused to take the psychotropic medication prescribed to her.

11. Respondent was discharged from Shoal Creek against medical advice with a diagnosis of AXIS 1—Schizoaffective disorder, bipolar type.

12. Respondent suffers from an undiagnosed, untreated mental illness that has been ongoing since at least 2006.

13. Respondent suffers from paranoia.

14. Respondent returned to work at Seton in December 2006 under a Texas Peer Assistance Program for Nurses (TPAPN) contract and Return to Work Agreement that required her to consult with a monitoring nurse before requesting a physician or critical response team for a patient and also required her to abide by the monitor's determination.

15. On January 13, 2007, Respondent inappropriately and inaccurately "diagnosed" that Patient MR # 296176 (Patient 1) was in congestive heart failure when an assessment by a physician and subsequent laboratory tests revealed the patient was not in acute congestive heart failure.

16. Respondent's nurse's notes for Patient 1 did not contain an appropriate nursing assessment but contained a diagnosis and plan of care for the patient.

17. On February 4, 2007, Respondent inappropriately and inaccurately "diagnosed" that Patient MR # 295180 (Patient 2) was "in trouble" and stated she was going to call the critical response team.

18. Although the Patient 2 was assessed and determined not to be in distress, Respondent continued to state the patient was in bad shape and needed a higher level of care.

19. Respondent's nurse's notes for Patient 2 did not contain an appropriate nursing assessment in that she documented a review of the lab results and the plan was to "open the airway, stabilize and blow off CO2...Guarded condition" which contradicted the physician's progress notes that did not indicate the patient's condition was guarded.

20. On February 11, 2007, Respondent insisted that the cast on Patient MR # 755166 (Patient 3) was too tight.

21. Patient 3 had undergone a right below-the-knee amputation with a cast on the stump to help placement of a prosthetic fitting.

22. Although Patient 3's cast was examined by the Orthopedic Unit charge nurse who determined it was not too tight, Respondent continued to insist the cast was too tight and engaged in a disruptive dispute with the Orthopedic Unit charge nurse and the fifth floor charge nurse over Patient 3's treatment.

23. A neurological evaluation completed in June 2007 showed Respondent has difficulty with rapid assimilation of verbal information and comprehension, which could affect Respondent's ability to recognize subtle signs, symptoms, or changes in patients' conditions, and Respondent's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing patients in potential danger.

24. Due to Respondent's signs of mental illness and inability to make clear decisions, she was placed on a leave of absence from February 11 to June 11, 2007, and eventually terminated from employment at Seton.

25. On June 10, 2010, Staff required Respondent to submit to an evaluation to determine whether her suspected mental impairment prevents her from practicing nursing with reasonable skill and safety.

26. Respondent did not undergo Staff's required evaluation.

27. Staff incurred administrative costs of $2,000 for the services of its expert witness Matthew Ferrara, Ph.D..

VIII. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to the Nursing Practice Act, TEX. OCC. CODE ANN. §§ 301.451 - 301.555.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law, pursuant to TEX GOV'T CODE ANN. ch. 2003 and TEX. OCC. CODE ANN. § 301.454.

3. Respondent received proper and timely notice of the hearing pursuant to the Administrative Procedure Act, TEX GOV'T CODE ANN. ch. 2001 and 22 TEX. ADMIN. CODE (TAC) §§ 13.10 and 213.22.

4. Based on the above Findings of Fact, Staff's allegations against Respondent were proven by a preponderance of the evidence.

5. Based on the above Findings of Fact and Conclusion of Law No. 4, Permanent License No. 225647 issued to Respondent should be suspended pending her submission to the Board of an evaluation that demonstrates her mental competency to practice nursing. TEX. OCC. CODE ANN. § 301.452(b)(10), (12), and (13); 22 TAC § 217.11(1)(B); and 22 TAC § 217.12(5) and (6)(C).

6. Pursuant to Finding of Fact No. 27, Respondent should be assessed $2,000 for Staff's administrative costs of this case. TEX. GOV'T CODE ANN. § 301.461.

SIGNED August 31, 2010.

Sharon Cloninger

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS