



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.  
*Katherine A. Thomas*  
Executive Director of the Board

IN THE MATTER OF § BEFORE THE TEXAS  
REGISTERED NURSE §  
LICENSE NUMBER 585126 §  
AND VOCATIONAL NURSE LICENSE §  
NUMBER 134386 §  
ISSUED TO MICHELLE ARLENE WINDHAM § BOARD OF NURSING

**NUNC PRO TUNC ORDER OF THE BOARD**

TO: Michelle Arlene Windham  
4432 Redbud Street  
Odessa, TX 79762

During open meeting held in Austin, Texas, the Texas Board of Nursing (Board) finds that an Order of the Board was mistakenly ratified and entered for Michelle Arlene Windham. The Order, which was heard and ratified by the Board on August 17, 2010, contains typographical errors on pages 5 and 6 of the Order regarding stipulation numbers 1 through 3. Upon notice and hearing, administrative agencies, like the Courts, have the power to enter nunc pro tunc orders where it can be seen by reference to a record that what was intended to be entered, but was omitted by inadvertence or mistake, can be corrected upon satisfactory proof of its rendition provided that no intervening rights will be prejudiced. *Railroad Comm'n v. McClain*, 356 S.W.2d 330, 334 (Tex. App.--Austin 1962, no writ) (citing *Frankfort Ky. Nat. Gas Co. v. City of Frankfort*, 276 Ky. 199, 123 S.W.2d 270, 272).

The Executive Director, as agent of the Texas Board of Nursing, after review and due consideration of the record and the facts therein, invalidates the Order of the Board for Michelle Arlene Windham that is dated August 17, 2010, and submits and enters the corrected Order of the Board, with the effective date of August 17, 2010. The corrected Order removes the phrase "the suspension being stayed" from stipulation numbers 1 through 3 on pages 5 and 6 of the Order so that the Order correctly reflects the phrase "entry of this Order". No other changes to the Order have been made. Ms. Windham received due process regarding her nursing license; therefore, her rights have not been prejudiced.

NOW, THEREFORE, IT IS ORDERED that the corrected Order of the Board is hereby approved and entered on the dates set forth below.

Order effective August 17, 2010.

Entered this 31st day of August, 2010.

TEXAS BOARD OF NURSING

*Katherine A. Thomas*

BY:

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KATHERINE A. THOMAS, MN, RN  
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse License Number 585126           §     AGREED  
And Vocational Nurse License Number 134386                   §  
issued to MICHELLE ARLENE WINDHAM                           §     ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of MICHELLE ARLENE WINDHAM, Registered Nurse License Number 585126 and Vocational Nurse License Number 134386, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on May 28, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's license to practice vocational nursing in the State of Texas is currently in delinquent status.
4. Respondent received a Certificate in Vocational Nursing from Odessa College, Odessa, Texas on May 10, 1991. Respondent was licensed to practice vocational nursing in the State of Texas on December 3, 1991. Respondent received an Associate Degree in Nursing from Odessa College, Odessa, Texas on May 15, 1992. Respondent was licensed to practice professional nursing in the State of Texas on August 31, 1992.

5. Respondent's nursing employment history includes:

12/91 - 8/94	Unknown	
9/1994 - 9/1996	RN	Texas Oncology Odessa, TX
9/1996 - 3/1997	RN	Circle of Life Hospice Odessa, TX
3/1997 - 3/1999	RN	Family Hospice Odessa, TX
3/1999 - 8/1999	RN	Medical Center Hospital-Medical Oncology Odessa, TX
8/1999 - 6/2003	RN	E.C.I.S.D.-Gale Pond Alamo Elementary School Odessa, TX
6/2003 - 1/2004	RN	ORMC - Labor and Delivery Odessa, TX
2/2004 - 3/2005	RN	Texas Oncology Odessa, TX
3/2005 - 3/2006	RN	Odyssey Hospice Odessa, TX
3/2006 - 3/2007	RN	Regency Hospital Odessa, TX
3/2007 - 7/2007	RN	ORMC/Allicance Hospital-Cardiac, Cath. Lab Odessa, TX
7/2007 - 11/2007	RN	ORMC-Labor and Delivery Odessa, TX
11/2007 - Present	RN	Medical Center Hospital Odessa, TX

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Registered Nurse with Medical Center Hospital, Odessa, Texas, and had been in this position for one (1) year and eight (8) months.
7. On or about July 1, 2009, while employed with Medical Center Hospital, Odessa, Texas, Respondent falsified medical records for Patient Medical Record Number 520579 in that she falsely documented at 10:30 that a baby crib was in the patient's room. At 15:15, another staff found the baby lying on the mother's chest without support, the side rails down, no blankets, and no crib in the room. In addition, Respondent made false entries in the Progress Notes/Nurses Notes in that she documented the status of the patient and her infant, and nursing care provided at 9:45, 10:30, and 12:00, the video-surveillance did not show Respondent entering the room at the times noted. Patient Medical Record Number 520579 was subsequently transferred to the Neonatal Intensive Care Unit for a higher level of care and later transferred to a higher level facility by air transport. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who would rely on the information while providing care to the patients. Respondent's conduct also exposed the patients unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes.
8. Regarding the conduct outlined in Finding of Fact Number Seven (7), Respondent states the policy at the time of the incident required a minimum of one RN to remain in the Newborn Nursery at all times if infants were present. On July 1, 2009, the Respondent and LVN S. Jones were the only nurses scheduled to staff the nursery.  
At 0945, as the policy requires, Respondent went to Labor and Delivery to assess and admit the infant following an uncomplicated SVD. No infants were in the Newborn Nursery at that time. Per policy, she performed Head to Toe assessment, obtained Vital Signs, checked CBG, measured and weighed the infant and administered the initial medications. The infant appeared stable and in no distress. The Respondent swaddled the infant and placed the infant in the mother's arms, per protocol. The mother was instructed on the use of a bulb syringe, who verbalized and demonstrated her understanding. The mother denied having any questions or concerns and was advised to contact the Labor and Delivery nurse with any needs, as per policy. The call bell was in reach.  
At approximately 1030, the infant was transferred from Labor and Delivery to room #758 by wheelchair in the mother's arms, as per policy. Respondent was unable to leave the Newborn Nursery at that time due to patients needing doctor's exams and additional procedures. The Labor and Delivery nurse went to the nursery to give a verbal report. The mother's Primary Nurse assessed the infant and advised the Respondent of the status. The Respondent states all of the nurses on the unit are cross-trained as Newborn Nursery, ante/post-partum and GYN nurses. The Respondent adds she was advised by the Labor and Delivery nurse that a crib was in the room. At 1200 entry, C. Powell, RN, Breast Lactation Educator, assisted the mother with breast-feeding the infant. The nurse advised the Respondent that no crib was in the room and the mother had the infant on the abdomen and did not wish to swaddle the infant as encouraged by C. Powell, RN.

At 1535 the infant was taken to the nursery in open crib by C. Powell, RN, for the first bath and returned to the room by C. Powell, RN, in stable condition and by open crib, since Respondent was unable to leave the nursery due to staffing. While the infant was in the nursery, the Respondent performed a second Head to Toe assessment. No changes were noted. At 1810, Respondent visited the room. At 1900 the report was given to the next shift. Respondent states in regards to the staffing issues and concerns regarding the Newborn Nursery, the nursery staff were expected to attend all deliveries, assist the doctors with their rounds, assist with all procedures and assume care for all infants on the floor. A scheduled evening staff meeting was held on July 1, 2009, where the Respondent advised the Director of the Unit, K. Abbott, RN, of her concerns. Ms. Abbott informed the staff and Respondent that the mother's primary nurse would be responsible for the care and charting of the infant if the nursery nurse was unable to perform those duties.

Respondent states the first indication of any reprimand, warning or advisement of the above allegations occurred at the time of her termination. Respondent was preparing for her approved disability leave beginning July 20, 2009 for a surgical procedure. Respondent adds she was terminated without warning on July 16, 2009 at approximately 1700 after working almost a complete 12 hour shift. She worked July 15, 2009 and July 16, 2009 as requested by the unit director due to staff shortage.

9. Formal Charges were filed on April 8, 2010.
10. Formal Charges were mailed to Respondent on April 9, 2010.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(B),(D),&(M), and 22 TEX. ADMIN. CODE §217.12(1)(A),(4),(6)(A)&(H).
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 585126 and Vocational Nurse License Number 134386, heretofore issued to MICHELLE ARLENE WINDHAM, including revocation of Respondent's license to practice professional and vocational nursing in the State of Texas.

#### ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL 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 SHALL 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 is 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) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted.

RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:* <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:* <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact

hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.*

(4) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars (\$500). RESPONDENT SHALL pay this fine within forty five (45) days of entry of this Order. 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 AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:**

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a

complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice

nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's license to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation 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 professional and vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 2nd day of June, 20 10.

Michelle Arlene Windham  
MICHELLE ARLENE WINDHAM, Respondent

Sworn to and subscribed before me this 2nd day of June, 20 10.

SEAL

Jenneva Hufford  
Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 22<sup>nd</sup> day of June, 2010, by MICHELLE ARLENE WINDHAM, Registered Nurse License Number 585126 and Vocational Nurse License Number 134386, and said Order is final.

Effective this 17th day of August, 2010.



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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse License Number 585126 § AGREED  
And Vocational Nurse License Number 134386 §  
issued to MICHELLE ARLENE WINDHAM § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of MICHELLE ARLENE WINDHAM, Registered Nurse License Number 585126 and Vocational Nurse License Number 134386, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on May 28, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's license to practice vocational nursing in the State of Texas is currently in delinquent status.
4. Respondent received a Certificate in Vocational Nursing from Odessa College, Odessa, Texas on May 10, 1991. Respondent was licensed to practice vocational nursing in the State of Texas on December 3, 1991. Respondent received an Associate Degree in Nursing from Odessa College, Odessa, Texas on May 15, 1992. Respondent was licensed to practice professional nursing in the State of Texas on August 31, 1992.

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11/2007 - Present	RN	Medical Center Hospital Odessa, TX

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Registered Nurse with Medical Center Hospital, Odessa, Texas, and had been in this position for one (1) year and eight (8) months.
  
7. On or about July 1, 2009, while employed with Medical Center Hospital, Odessa, Texas, Respondent falsified medical records for Patient Medical Record Number 520579 in that she falsely documented at 10:30 that a baby crib was in the patient's room. At 15:15, another staff found the baby lying on the mother's chest without support, the side rails down, no blankets, and no crib in the room. In addition, Respondent made false entries in the Progress Notes/Nurses Notes in that she documented the status of the patient and her infant, and nursing care provided at 9:45, 10:30, and 12:00, the video-surveillance did not show Respondent entering the room at the times noted. Patient Medical Record Number 520579 was subsequently transferred to the Neonatal Intensive Care Unit for a higher level of care and later transferred to a higher level facility by air transport. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who would rely on the information while providing care to the patients. Respondent's conduct also exposed the patients unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes.
  
8. Regarding the conduct outlined in Finding of Fact Number Seven (7), Respondent states the policy at the time of the incident required a minimum of one RN to remain in the Newborn Nursery at all times if infants were present. On July 1, 2009, the Respondent and LVN S. Jones were the only nurses scheduled to staff the nursery.  
At 0945, as the policy requires, Respondent went to Labor and Delivery to assess and admit the infant following an uncomplicated SVD. No infants were in the Newborn Nursery at that time. Per policy, she performed Head to Toe assessment, obtained Vital Signs, checked CBG, measured and weighed the infant and administered the initial medications. The infant appeared stable and in no distress. The Respondent swaddled the infant and placed the infant in the mother's arms, per protocol. The mother was instructed on the use of a bulb syringe, who verbalized and demonstrated her understanding. The mother denied having any questions or concerns and was advised to contact the Labor and Delivery nurse with any needs, as per policy. The call bell was in reach.  
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At 1535 the infant was taken to the nursery in open crib by C. Powell, RN, for the first bath and returned to the room by C. Powell, RN, in stable condition and by open crib, since Respondent was unable to leave the nursery due to staffing. While the infant was in the nursery, the Respondent performed a second Head to Toe assessment. No changes were noted. At 1810, Respondent visited the room. At 1900 the report was given to the next shift. Respondent states in regards to the staffing issues and concerns regarding the Newborn Nursery, the nursery staff were expected to attend all deliveries, assist the doctors with their rounds, assist with all procedures and assume care for all infants on the floor. A scheduled evening staff meeting was held on July 1, 2009, where the Respondent advised the Director of the Unit, K. Abbott, RN, of her concerns. Ms. Abbott informed the staff and Respondent that the mother's primary nurse would be responsible for the care and charting of the infant if the nursery nurse was unable to perform those duties.

Respondent states the first indication of any reprimand, warning or advisement of the above allegations occurred at the time of her termination. Respondent was preparing for her approved disability leave beginning July 20, 2009 for a surgical procedure. Respondent adds she was terminated without warning on July 16, 2009 at approximately 1700 after working almost a complete 12 hour shift. She worked July 15, 2009 and July 16, 2009 as requested by the unit director due to staff shortage.

9. Formal Charges were filed on April 8, 2010.
10. Formal Charges were mailed to Respondent on April 9, 2010.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(B),(D),&(M), and 22 TEX. ADMIN. CODE §217.12(1)(A),(4),(6)(A)&(H).
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 585126 and Vocational Nurse License Number 134386, heretofore issued to MICHELLE ARLENE WINDHAM, including revocation of Respondent's license to practice professional and vocational nursing in the State of Texas.

#### ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL 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 SHALL 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 is 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) RESPONDENT SHALL, within one (1) year of entry of this Order the suspension being stayed, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on

malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order the suspension ~~being stayed~~, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order the suspension ~~being stayed~~, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact

hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.*

(4) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars (\$500). RESPONDENT SHALL pay this fine within forty five (45) days of entry of this Order. 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 AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:**

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a

complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice

nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's license to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation 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 professional and vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 22nd day of June, 2010.

Michelle Arlene Windham

MICHELLE ARLENE WINDHAM, Respondent

Sworn to and subscribed before me this 22nd day of June, 2010.

SEAL

Jenneva Hufford

Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 22<sup>nd</sup> day of June, 2010, by MICHELLE ARLENE WINDHAM, Registered Nurse License Number 585126 and Vocational Nurse License Number 134386, and said Order is final.

Effective this 17th day of August, 2010.



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