



**DOCKET NUMBER 507-10-1559**

**IN THE MATTER OF  
PERMANENT CERTIFICATE  
NUMBER 720058  
ISSUED TO  
PEGGY ANN TOMLINSON**

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**BEFORE THE STATE OFFICE  
OF  
ADMINISTRATIVE HEARING**

*Patricia P. Thomas*  
Executive Director of the Board  
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.

**OPINION AND ORDER OF THE BOARD**

TO: PEGGY ANN TOMLINSON  
2014 HIGH HILL ROAD  
DARLINGTON, SC 29532

PRATIBHA J. SHENOY  
ADMINISTRATIVE LAW JUDGE  
300 WEST 15TH STREET  
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 21-22, 2010, 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 Peggy Ann Tomlinson with 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. Both Staff and the Respondent filed exceptions to the PFD. Staff also filed a response to Respondent's exceptions. The ALJ issued a ruling on August 9, 2010, declining to make any changes to the PFD, except that the ALJ agreed that Conclusion of Law Number 10 should be re-designated as a recommendation.

The Board, after review and due consideration of the PFD, Staff's exceptions, Respondent's exceptions, Staff's response, 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, with the exception that Conclusion of Law Number 10 is re-designated as a recommendation.\* 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 RESPONDENT SHALL receive the sanction of a REPRIMAND WITH A FINE, 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 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, 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:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to PEGGY ANN TOMLINSON to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order.

(2) 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>.

(3) RESPONDENT SHALL pay a monetary fine in the amount of two hundred fifty dollars (\$250). 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.

(4) RESPONDENT SHALL pay an administrative reimbursement in the amount of one thousand eight hundred nineteen dollars (\$1,819). RESPONDENT SHALL pay this fine within one hundred thirty five (135) 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 ORDERED, 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 TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) 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) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The 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) For the remainder of the stipulation period, 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.

(9) 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 two (2) years of employment as a nurse.

(10) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to an evaluation by a Board approved physician specializing in Pain Management or Psychiatry. The performing evaluator will submit a written report to the Board's office, including results of the evaluation, clinical indications for the prescriptions, and recommendations for on-going treatment within thirty (30) days from the Board's request.**

(11) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month

period, random screens shall be performed at least once per week. For the next three (3) month period, random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. For the remainder of the stipulation period, random screens shall be performed at least once every three (3) months. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis are the sole method accepted by the Board.

Specimens shall be screened for at least the following substances:

Amphetamines	Meperidine
Barbiturates	Methadone
Benzodiazepines	Methaqualone
Cannabinoids	Opiates
Cocaine	Phencyclidine
Ethanol	Propoxyphene
tramadol hydrochloride (Ultram)	

A Board representative may appear at the RESPONDENT'S place of employment at any time during the stipulation period and require RESPONDENT to produce a specimen for screening.

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation period.

Any positive result for which the nurse does not have a valid prescription or failure to report for a drug screen, which may be considered the same as a positive result, will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and

nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

(12) RESPONDENT SHALL participate in pain management therapy with a Board approved Medical Doctor or Doctor of Osteopathy, licensed by the Texas Medical Board, and certified as a Diplomat with the American Board of Pain Medicine. RESPONDENT SHALL CAUSE the physician to submit written reports to the Board, which shall include, at a minimum, the clinical indications and rationale for the chronic use of controlled substances, RESPONDENT's progress and compliance with pain management therapy, and a prognosis as to RESPONDENT's ability to safely practice nursing in a direct patient care setting. Such reports are to be furnished each and every month for three (3) months. If therapy is recommended for beyond three (3) months, the reports shall then be required at the end of each three (3) month period for the duration of the stipulation period, or until RESPONDENT no longer requires the use of controlled substances.

IT IS FURTHER ORDERED, 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.



Entered this 22<sup>nd</sup> day of October, 2010.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-10-1559 (June 15, 2010).

\* This re-designation is authorized under the Government Code §2001.058(e). Authority is also found in *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears v. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App.-Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n v. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App.-Austin 2005, pet. denied). Further, the ALJ re-designated Conclusion of Law Number 10 as a recommendation in her letter ruling of August 9, 2010.

# State Office of Administrative Hearings



Cathleen Parsley  
Chief Administrative Law Judge

June 15, 2010

Katherine A. Thomas, M.N., R.N.  
Executive Director  
Texas Board of Nursing  
333 Guadalupe, Tower III, Suite 460  
Austin, Texas 78701

**VIA INTER-AGENCY**

**RE: Docket No. 507-10-1559, In the Matter of Permanent Certificate No. 720058 Issued to Peggy Ann Tomlinson**

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 TEX. ADMIN. CODE § 155.507(c), a SOAH rule which may be found at [www.soah.state.tx.us](http://www.soah.state.tx.us).

Sincerely,

A handwritten signature in cursive script that reads "Pratibha J. Shenoy".

Pratibha J. Shenoy  
Administrative Law Judge

PJS/slc

Enclosures

XC: Jena Abel, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTER-AGENCY**  
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTER-AGENCY**  
Peggy Ann Tomlinson, 2014 High Hill Road, Darlington, SC 29532-**VIA REGULAR MAIL**

SOAH DOCKET NO. 507-10-1559

IN THE MATTER OF PERMANENT § BEFORE THE STATE OFFICE  
CERTIFICATE NO. 720058 ISSUED TO § OF  
PEGGY ANN TOMLINSON § ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Respondent Peggy Ann Tomlinson, a registered nurse (RN) licensed by the Board. Ms. Tomlinson was working in Lancaster, Texas, during the June-August 2006 time period, and currently resides and works as a nurse in South Carolina. Staff alleges that Ms. Tomlinson is subject to discipline under the Texas Nursing Practice Act<sup>1</sup> (Act) in connection with a positive drug screen for methadone in July 2006, and two incidents in June and August 2006, during which Ms. Tomlinson allegedly exhibited a lack of fitness to practice professional nursing.

After considering the evidence, the Administrative Law Judge (ALJ) determines that Ms. Tomlinson is subject to sanction for lack of fitness to practice professional nursing in August 2006. The ALJ recommends that Ms. Tomlinson be reprimanded; ordered to pay a fine of \$250.00 and Board costs of \$1,819.00; take a nursing jurisprudence class;<sup>2</sup> and be required to notify her current employer of the Board's order.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Jurisdiction and notice were not contested, and those matters are addressed only in the Findings of Fact and Conclusions of Law below. Due to scheduling difficulties for the parties, the hearing was held in two parts, on March 18 and April 9, 2010, at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel Jena Abel

<sup>1</sup> TEX. OCC. CODE ch. 301 *et seq.*

<sup>2</sup> If acceptable to the Board, a nursing jurisprudence course or other appropriate educational program taught in South Carolina or through remote means may reduce the burden of compliance for Ms. Tomlinson.

represented Staff. Ms. Tomlinson appeared *pro se*, assisted by her husband, Kevin Tomlinson. Ms. Tomlinson participated in person on the first day of hearing, and via telephone on the second day. The record closed April 16, 2010, with the filing of arguments related to the Board's costs.

## II. STAFF'S CHARGES AND APPLICABLE LAW

### A. Staff's Charges

Staff alleges that Ms. Tomlinson was unfit to practice nursing on June 24 and August 3, 2006, and that she engaged in the intemperate use of a controlled substance, methadone, on July 25, 2006. Staff asserts that Ms. Tomlinson's behavior, when exhibited by a registered nurse while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms, or changes in a patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

### B. Applicable Law

Staff asserts Ms. Tomlinson's actions constitute grounds for disciplinary action under the Act and the Board's rules, which authorize sanctions against a licensee for:

- Intemperate use of alcohol or drugs that the Board determines endangers or could endanger a patient. Act § 301.452(b)(9).<sup>3</sup>
- Unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public. Act § 301.452(b)(10).
- Lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public. Act § 301.452(b)(12).
- Failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm. Act § 301.452(b)(13).

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<sup>3</sup> All statutory references and citations to the Board's rules reflect provisions in effect during the June-August 2006 period.

- Failure to accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability. **22 TEX. ADMIN. CODE § 217.11(1)(T).**<sup>4</sup>
- Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care. **Board Rule 217.12(1)(E).**
- Inability to Practice Safely--demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition. **Board Rule 217.12(5).**
- Use of any controlled substance or any drug, prescribed or unprescribed, or device or alcoholic beverages while on duty or on call and to the extent that such use may impair the nurse's ability to safely conduct to the public the practice authorized by the nurse's license. **Board Rule 217.12(10)(A).**

### III. EVIDENCE

#### A. Overview of Staff's Evidence

Staff introduced records showing that Ms. Tomlinson has been licensed in Texas since August 2005.<sup>5</sup> Also in evidence are personnel records concerning Ms. Tomlinson from Liberty Dialysis in Lancaster, Texas; lab results and related documents from Ms. Tomlinson's July 2006 drug screen; medical records from Ms. Tomlinson's treating physician; documents concerning Ms. Tomlinson from the Texas Peer Assistance Program for Nurses (TPAPN); and affidavits of various persons who had worked with Ms. Tomlinson.<sup>6</sup> In addition, Staff called Ms. Tomlinson and the following individuals as witnesses:

- Noemi Leal, a Supervising Investigator for the Board who conducted an investigation into Ms. Tomlinson's actions at Liberty Dialysis;
- Bonnie Cone, RN, a Nursing Consultant for Practice to the Board; and

<sup>4</sup> For convenience, citations to title 22, part 11, chapter 217 of the Texas Administrative Code will be to "Board Rule 217.xx."

<sup>5</sup> State's Ex. 1.

<sup>6</sup> State's Ex. 6.

- Persons who worked with Ms. Tomlinson at Liberty Dialysis: Sherry Green, RN; Dyaimdee "Tony" Johnson, Chief Patient Care Technician (PCT); Lacibironda McClellan, PCT; and Marsha Irani, administrative assistant.

Staff's allegations, as detailed further below, are that Ms. Tomlinson: called in sick to work after a shift had begun on June 24, 2006, putting patients at risk of inadequate staff coverage; engaged in the intemperate use of methadone as reflected by a drug screen on July 25, 2006; and put patients in danger with her actions on August 3, 2006.

#### **B. Overview of Respondent's Evidence**

Ms. Tomlinson provided documentary evidence of: her qualifications;<sup>7</sup> prescription medications she was taking in 2006;<sup>8</sup> correspondence between her doctor and Liberty Dialysis;<sup>9</sup> and drug screen results.<sup>10</sup> She testified on her own behalf, and called the following witnesses:

- Persons who worked with her at Liberty Dialysis: Demetria Collins, Licensed Master Social Worker (LMSW); Barry Sorisantos, RN; and Arfrances Johnson, Registered Dietitian; and
- Dr. Nagaraj Kikkeri, Ms. Tomlinson's treating physician.

The parties stipulated that Staff and the Board have no knowledge of any allegations of misconduct by Ms. Tomlinson subsequent to the 2006 incidents at issue in this proceeding. There also is no evidence of any pre-2006 disciplinary action against Ms. Tomlinson.

#### **C. Charge I**

Ms. Tomlinson began working at Liberty Dialysis in September 2005. Records from Liberty Dialysis indicate that on June 24, 2006, Ms. Tomlinson called in sick, leaving a recorded message for Ms. Green, the facility administrator.<sup>11</sup> Ms. Green testified that in the message,

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<sup>7</sup> Resp. Ex. 1a-1n.

<sup>8</sup> Resp. Ex. 2a-2e.

<sup>9</sup> Resp. Ex. 3a-3c.

<sup>10</sup> Resp. Ex. 4a-4d.

<sup>11</sup> State's Ex. 6 at 2 and 30 reference the voicemail message. No audiotape of the message was offered.

Ms. Tomlinson was crying, her speech was slurred, and she was asking for help. Ms. Green was alarmed and asked the Lancaster police to respond to Ms. Tomlinson's home. Ms. Green later received a call from the Dallas police, informing her that they had taken a dispatch from Lancaster police, and had visited Ms. Tomlinson to confirm that she was fine.

Ms. Green could not recall the time the voicemail message was left by Ms. Tomlinson. However, Liberty Dialysis staff were required to call in two hours prior to the start of a shift to cancel due to illness. On a July 27, 2006 memorandum, Ms. Green noted that Ms. Tomlinson "made this call after the shift had started."<sup>12</sup> According to Ms. Green, Ms. Tomlinson's actions potentially endangered Liberty Dialysis patients because the lateness of the call decreased the number of staff available. Liberty Dialysis is required to have a certain number of licensed staff on duty in order to provide adequate patient coverage, and a late cancellation by one staff member can make it difficult to arrange a substitution.

Ms. Irani, Mr. Johnson and Ms. McClellan also heard the voicemail message and confirmed that it was troubling, but none of them knew when the call was made. Ms. Tomlinson stated that she sounded distressed on the voicemail message simply because she was ill. Further, she cited the fact that she left a message as evidence that no one was present to take her call, thus supporting her contention that she called before her shift started.

### C. Charge II

Ms. Green, Ms. Irani, Mr. Johnson and Ms. McClellan testified that in mid-2006, Ms. Tomlinson began exhibiting changes in behavior and appearance. These witnesses noticed some or all of the following changes: Ms. Tomlinson's hair began to look brittle, she had scabbed sores on her arms, she began wearing long sleeves more often, and she appeared either jittery or sluggish at times. Ms. Green added that Ms. Tomlinson had developed a habit of calling in sick on paydays and had been given a verbal warning for her pattern of absences. On July 25, 2006, Ms. Green called a meeting with Ms. Tomlinson to address the June 24, 2006 voicemail message, her absenteeism, and whether anything was wrong, as suggested by the

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<sup>12</sup> State's Ex. 6 at 30.

changes in her appearance. Ms. Green asked Mr. Johnson to attend the meeting as a witness and as a management representative. She also asked Ms. Irani to take notes at the meeting, since Ms. Irani maintained the personnel records.

During the meeting, Ms. Green played the voicemail message, which Ms. Tomlinson acknowledged that she had recorded. Ms. Tomlinson stated that she had been taking methadone under a doctor's supervision for chronic pain in her neck and arm. According to Ms. Green, Liberty Dialysis required staff to report the medications they were taking, and indicate whether such medications could impair judgment or have other side effects. Prior to the meeting, Ms. Green was unaware Ms. Tomlinson was taking a controlled substance, albeit with a prescription. Under Liberty Dialysis' drug testing policy, Ms. Green sent Ms. Tomlinson for immediate drug testing. She also told Ms. Tomlinson that if the drug screen was positive, Ms. Tomlinson would be given a "second chance" only if she enrolled in TPAPN.<sup>13</sup>

Ms. Irani and Mr. Johnson accompanied Ms. Tomlinson to the drug screening facility. The drug screen reflected a positive result for methadone.<sup>14</sup> After Ms. Tomlinson provided documents from her physician detailing the medications she was taking, Ms. Green referred Ms. Tomlinson to TPAPN.<sup>15</sup>

Ms. Tomlinson argued that Ms. Green was attempting to assign blame for the theft of certain drugs from Liberty Dialysis, and had incorrectly assumed that the sores on Ms. Tomlinson's arms were from drug use, rather than a reaction to insect bites. Ms. Green allegedly also chose Ms. Tomlinson as a scapegoat because she feared Ms. Tomlinson might take her job. The stolen drugs, Ms. Tomlinson noted, did not appear on the drug screen she took. In fact, according to Ms. Tomlinson, methadone is not ordinarily included on a drug screen unless specifically requested; Ms. Green would not have had a reason to request a methadone test if Ms. Tomlinson had not volunteered the information. Ms. Tomlinson said she told Ms. Green about her use of methadone because she wanted to prove through the drug screen that she was not taking any drugs other than those prescribed by her physician.

<sup>13</sup> See State's Ex. 6 at 2; 29-30; 36-37.

<sup>14</sup> State's Ex. 6 at 32-33; Resp. Ex. 4b.

<sup>15</sup> State's Ex. 6 at 29-30.

As evidence of Ms. Green's alleged motives, Ms. Tomlinson argued that if Ms. Green was truly concerned about her well-being, Ms. Collins, as the facility's social worker, would have been asked to attend the July 25, 2006 meeting. In addition, she questioned why neither Ms. Green nor any other Liberty Dialysis staff members sought to obtain medical attention or other assistance for her if they thought she was suffering from addiction or illness. Ms. Tomlinson asserted that the "pattern of absenteeism" alleged by Ms. Green actually matched the dates Ms. Tomlinson was excused from work by her doctor so that she could receive injections as part of her pain treatments. Ms. Tomlinson acknowledged that methadone can cause cognitive impairment but denied experiencing any negative side effects. Rather, she found that it gave her energy and enabled her to perform her duties without pain. She noted that methadone gave her fewer side effects than other narcotic pain medications she had taken, including oxycodone.

Ms. Tomlinson called Dr. Kikkeri, her treating physician, as a witness. Dr. Kikkeri specializes in anesthesia and pain management, and is certified by the American Board of Pain Management. He treated Ms. Tomlinson for neck and arm pain with spinal injections of pain medicines in February, March and June 2006, periodic steroid injections in the neck, and prescription medications including methadone. Each month from January to July 2006, he wrote a prescription for Ms. Tomlinson for three 10-milligram tablets of methadone to be taken each morning. When asked to characterize the dosage, Dr. Kikkeri noted that dosage is "highly individualized." For a "naïve" patient – i.e., one who has not previously used any narcotics – Ms. Tomlinson's prescription could be considered a high dose, at least initially. However, for a patient who has previously used narcotic medications, the dose would be considered low to medium. Dr. Kikkeri did not have immediate access to Ms. Tomlinson's records, but said that he prescribes methadone only if it is clearly necessary, so he believes Ms. Tomlinson would have been taking other narcotic medications previously.

Dr. Kikkeri's usual practice is to develop a pain management plan and to monitor the use of methadone for adverse reactions and dependence, although he noted that methadone has a lower risk of dependence compared to other narcotics. It is also his practice to conduct drug screens to ensure that patients are taking medications appropriately and to require patients to be

seen no less than once a month. Because he did not have access to Ms. Tomlinson's records, he could not verify whether or how these practices had been followed in Ms. Tomlinson's case.

Dr. Kikkeri said the possible side effects of methadone are a depressed central nervous system, impaired judgment, constipation, nausea, vomiting, and dependence. Respiratory depression is the primary symptom of excessive use of methadone. As a general matter, it is unusual to have side effects of methadone develop "suddenly" for a patient who has tolerated the drug for a year or so. If a patient exhibits symptoms such as slurred speech, altered mental status or shuffling feet, Dr. Kikkeri stated that a number of illnesses could be the source, such as a disease of the brain or vocal cords, stroke, a neuromuscular disorder, or low blood sugar.

#### **D. Charge III**

Staff's third and most serious charge relates to Ms. Tomlinson's behavior on the morning of August 3, 2006, when she is asserted to have put patients in danger because of her unfitness to practice. Ms. Green and Ms. McClellan testified that, as an outpatient dialysis center, Liberty Dialysis serves patients who are in compromised health. Patients often have shunts or other "access points" implanted in their veins or sometimes directly into an organ, such as the heart, to facilitate a connection with the dialysis equipment. In lay terms, dialysis removes blood from the patient, cleanses it of impurities and toxins (a process that the patient's kidneys can no longer adequately perform), and returns the blood to the patient. The work requires staff to monitor patients' vital signs closely at all times. A particular danger is that improperly performed dialysis may cause blood loss or may introduce air into the patient's bloodstream. Air bubbles can travel to the heart or brain, presenting the risk of an embolism, stroke, or other serious event.

Mr. Johnson is certified by the dialysis machine manufacturer and maintained the Liberty Dialysis equipment. He testified that the machines have a fail-safe mechanism. When a dialysis machine is properly set up, an alarm will sound and the fail-safe mechanism will automatically shut off the system if a problem is detected in a line, such as air in the system or loss of pressure. However, if the fail-safe mechanism is not properly attached to the patient's line before the dialysis process is initiated, the mechanism will not be able to engage the shut-off clamp.

Ms. McClellan has worked as a PCT at Liberty Dialysis since December 2005. Patients begin arriving by 5:15 a.m. each day, so staff reports for the morning shift around 4:30 a.m. On the morning of August 3, 2006, Ms. McClellan noticed that Ms. Tomlinson was "walking as if in a haze, stumbling, and shuffling her feet." This behavior was unusual, but when Ms. McClellan inquired, Ms. Tomlinson said she was just tired. Shortly thereafter, Ms. McClellan noticed Ms. Tomlinson working on a dialysis machine with J.L., a patient with a catheter implanted in his heart. According to Ms. McClellan, the dialysis machine's alarm was sounding, and the safety clamp mechanism had not been engaged. Without the safety clamp to stop the system, "the machine was pulling the patient's blood," which was spattered on "the wall, the floor, and the machine next to" Ms. Tomlinson. Ms. McClellan asked Ms. Tomlinson if she needed help, and testified that Ms. Tomlinson did not respond and "simply kept pushing the 'reset' button."

At that point, Ms. McClellan intervened and said that she would handle the patient. J.L. "looked like a deer caught in the headlights" and appeared afraid. Ms. McClellan herself was shocked, given that Ms. Tomlinson in the past had been "almost obsessive-compulsive" about procedures. Ms. McClellan's recollection is that while she prepared a new set-up for J.L., Mr. Johnson escorted Ms. Tomlinson away and asked her to wait in the break room.

Mr. Johnson testified that two of the PCTs came to him and said that "something is not right with" Ms. Tomlinson. He telephoned Ms. Green and advised her that she should come to the facility to assess the situation. When Mr. Johnson approached the dialysis machine where Ms. Tomlinson was working, he heard the alarm sounding, saw blood on the floor, the wall and the adjoining machine, and saw Ms. Tomlinson pressing the machine's "reset" button. Ms. Tomlinson held a syringe, and was attempting to remove air from the dialysis system. Mr. Johnson saw that the fail-safe clamp mechanism had been disconnected. He asked Ms. Tomlinson to stop and to wait for him to clean up the blood spill. After he repeated himself several times, Ms. Tomlinson walked away, stumbling on the way. Mr. Johnson observed that J.L. looked scared. He asked Ms. McClellan and Mr. Sorisantos to assist with the patients. Although small blood spills may occur in the dialysis process, the amount of blood Mr. Johnson cleaned up was significant and clearly out of the ordinary. Earlier that morning Mr. Johnson had

observed Ms. Tomlinson come into the break room, stumble, and catch herself before falling. She did not return Mr. Johnson's greeting and appeared very preoccupied.

Mr. Sorisantos, called as a witness by Ms. Tomlinson, averred that she was a very good nurse in general. Nevertheless, on August 3, 2006, he found her behavior inexplicable, and said that she was not herself. Mr. Sorisantos was the charge nurse that day. As he made his rounds, he noticed Ms. Tomlinson attending to a patient whose saline line was unclamped. He said that a prudent nurse would have clamped that line immediately, and he was very concerned that excess saline was flowing into the patient. He explained that while some patients receive saline infusions to treat blood pressure problems, that particular patient did not require saline. It was later determined that "almost a liter" of saline was infused into the patient, which is "a big no-no, never acceptable" for an asymptomatic patient. Mr. Sorisantos tried to get Ms. Tomlinson's attention, but she was "smiling and staring at something" and did not respond to his questions. Mr. Sorisantos' recollection is that he took Ms. Tomlinson away from the area and told Ms. Green he was concerned about Ms. Tomlinson's behavior. He does not remember whether he later put patient J.L. on a dialyzer. Although he does not recall seeing the blood spill, Mr. Sorisantos remembers being told about it.

That morning, Ms. Green received calls from Mr. Johnson and later from another PCT, advising her that Ms. Tomlinson was exhibiting alarming behavior and the situation needed to be assessed. During the second call, Ms. Green asked to speak to Mr. Sorisantos, who told her that Ms. Tomlinson was not following directions and was acting very strangely. Ms. Green arrived at approximately 7:30 a.m.,<sup>16</sup> and saw Ms. Tomlinson walking towards her in a sluggish manner, shuffling her feet, with her body leaning sideways. When asked if she was feeling alright, Ms. Tomlinson said she was tired. Ms. Green took Ms. Tomlinson into her office and asked her to sit down. Ms. Green asked if Ms. Tomlinson was aware of swaying back and forth in the chair, to which Ms. Tomlinson replied, "Oh, am I?" Ms. Green advised Ms. Tomlinson that she was in no condition to work and asked Ms. Irani to drive Ms. Tomlinson home. On August 5, 2006, Ms. Green told Ms. Tomlinson she was being terminated for the reasons set

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<sup>16</sup> State's Ex. 6 at 39. A memorandum prepared by Ms. Green summarizing the events of August 3, 2006 (Discharge Memorandum) states that she arrived at 7:30 a.m. In her testimony, however, Ms. Green said that she arrived sometime "between 6 and 7, when it was still dark outside."

forth in the Discharge Memorandum. Ms. Tomlinson signed each page of the Discharge Memorandum.<sup>17</sup>

Ms. Irani's testimony was consistent with that of Mr. Johnson and Ms. McClellan. She observed the dialysis machine's alarm sounding, and Ms. Tomlinson standing nearby with shaking hands and glazed eyes, looking "as if she had not slept for days." When Ms. Tomlinson left the area, she was "walking at an angle."

Ms. Collins, a licensed social worker who worked at Liberty Dialysis with Ms. Tomlinson, testified that she did not hear the June 24, 2006 voicemail message, did not participate in the July 25, 2006 meeting with Ms. Tomlinson and Ms. Green, and was not present on the morning of August 3, 2006. However, she stated that she had a high regard for Ms. Tomlinson's abilities, and suggested that Ms. Green often failed to follow protocols for disciplinary actions. If a patient – such as J.L. – had complained about a nurse, Ms. Collins would have investigated, but she never received any complaints about Ms. Tomlinson.

Ms. Johnson, who was a registered dietitian at Liberty Dialysis, testified that Ms. Tomlinson was professional and always dressed appropriately. Like Ms. Collins, Ms. Johnson did not hear the June 24, 2006 tape, and did not witness either the July 25, 2006 meeting or the events of August 3, 2006. However, Ms. Johnson attended the monthly Continuous Quality Improvement (CQI) meetings that Liberty Dialysis was required to hold. All blood spills, patient complaints, and other incidents were required to be addressed at CQI meetings, and Ms. Johnson cannot recall any patient complaints about Ms. Tomlinson, or any discussions of the August 3, 2006 blood spill at a CQI meeting. Ms. Johnson echoed Ms. Collins' comment that Ms. Green often made unprofessional remarks and had favorites among the staff, particularly the PCTs. Ms. Johnson questioned why Ms. Tomlinson would have "completed her shift" on August 3, 2006 if she was as impaired as claimed by other witnesses.

Called as a rebuttal witness, Ms. Green stated that in fact, the blood spill *had* been discussed at a CQI meeting. Ms. Green noted that Ms. Johnson was a part-time employee, and

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<sup>17</sup> State's Ex. 6 at 38-39.

she believes Ms. Johnson missed a few CQI meetings. Further, Ms. Green testified that Ms. Tomlinson was in the treatment area, but not allowed to work on patients, in the time after the blood spill with J.L. Ms. Tomlinson did not finish her shift because she was driven home by Ms. Irani.

Ms. Tomlinson was adamant that she had done nothing wrong and had never put a patient at risk. At worst, she was very tired, because she had been "up all night moving" into a new home. In her 32 years of nursing experience, she has never had any allegations of misconduct made against her apart from those at issue here, has never been disciplined, and has never been fired from a position, other than Liberty Dialysis.

Ms. Tomlinson suggested that the symptoms she exhibited, which several witnesses said was out of character for her, could also be consistent with a number of diseases or medical conditions, as noted by Dr. Kikkeri. She emphasized the failure of the Liberty Dialysis personnel to seek medical help for her, if they were concerned about her health or behavior.

The account of events offered by Ms. Tomlinson differed markedly from the other witnesses who were present on August 3, 2006. She suggested that the difference is due to several of the witnesses colluding, or rehearsing their testimony at the instigation of Ms. Green. Ms. Tomlinson stated that on August 3, 2006, she never "put J.L. on the machine," but rather was troubleshooting another staff member's set-up. She denied that either Mr. Johnson or Mr. Sorisantos took her out of the treatment area, and denied that Ms. McClellan needed to use a new set-up for J.L. Ms. Tomlinson took issue with the description provided by Mr. Johnson, Ms. McClellan, and Mr. Sorisantos of the fail-safe mechanism on the dialysis machine. They stated that the machine would not engage the fail-safe clamp if the dialysis line had not been inserted properly. In contrast, Ms. Tomlinson stated that the dialysis machine could not function if the fail-safe mechanism was not enabled, and that if she had not assembled the set-up properly, the alarm could not have sounded at all. She also stated that "it is not uncommon" to have blood spills on the floor, wall, or ceiling in a dialysis center.

To the extent that patient J.L. was being given saline, Ms. Tomlinson suggested it was because there was a blood clot in his dialysis line. The Discharge Memorandum states that J.L. was weighed at 12:09 p.m. that day, and notes that J.L. "is upset because he has 2 [kilograms] of fluid on that he states he 'did not come in with.' Presumably this fluid came from [Ms. Tomlinson] trying to get the air out of the patient's lines and dialyzer." Ms. Tomlinson argues that this statement is proof that she could not have been responsible for the excess saline, as she had already been driven home by Ms. Irani much earlier that day. Although she signed each page of the Discharge Memorandum, Ms. Tomlinson averred that at that point, it did not make a difference what she signed, and she did not read the memorandum before signing it.

Ms. Tomlinson also disputes Ms. Green's account of their conversation that morning. According to Ms. Tomlinson, she told Ms. Green she was feeling very tired after moving, and asked Ms. Green to take over. Although she denies that she was impaired in any way other than being tired, Ms. Tomlinson acknowledged that she might have been experiencing an impairment from a medical event, such as low blood sugar or an illness, the symptoms of which she might not have been able to recognize in herself. In that case, however, she argued that Liberty Dialysis staff were imprudent in sending her home and not getting medical attention for her, since she "could have died" if, for example, she had experienced a stroke.

TPAPN was also not helpful to her, Ms. Tomlinson stated, because the program is meant for nurses who are addicted to drugs or alcohol, and she was never addicted. Rather, she was under the care and supervision of Dr. Kikkeri. For that reason, "TPAPN wouldn't take me." Ms. Tomlinson emphasized the responsibilities she holds at her current position, where she is a charge nurse at a Level II trauma center, serves as a sexual assault examiner, obtains blood and urine samples for law enforcement use, and maintains advanced credentials such as pediatric advanced life support, advanced adult cardiac life support, and trauma nursing.

#### **G. Other Evidence, Including Evidence Relating to Sanction**

Ms. Leal testified about her investigation of Ms. Tomlinson's actions at Liberty Dialysis. Based on the "Nurse's Drug Guide, 2006 edition" (Drug Guide), Ms. Leal stated that the dose of

methadone being taken by Ms. Tomlinson was “high” for an adult. The literature, later entered into evidence by Ms. Tomlinson, states that for “moderate to severe acute pain,” the adult dose is 2.5 to 10 milligrams every 3-4 hours as needed.<sup>18</sup> The Drug Guide also states that the adult dose for “chronic pain” is 5-20 milligrams every 6-8 hours, and that the “detoxification treatment” adult dose is 15-40 milligrams once a day. Ms. Tomlinson was prescribed a dose of 30 milligrams (three 10-milligram tablets) each morning. Ms. Leal concluded that, according to the Drug Guide, Ms. Tomlinson was taking a “high” dose for pain. Based on her investigation, Ms. Leal believes the charges presented by Staff are substantiated by the evidence.

Ms. Cone has been a registered nurse for more than 20 years. She is certified as a Forensic Nurse and as a Sexual Assault Nurse Examiner (adult, adolescent and pediatric) and belongs to several professional associations.<sup>19</sup> She has helped develop professional guidelines and training courses and has presented academic papers. Since August 2009, Ms. Cone has served as a Nursing Consultant for Practice to the Board. As part of her duties, she advises nurses, members of the public, and the Board on nursing practice issues and interpretations of Board rules. The ALJ recognized Ms. Cone as an expert on the Board’s rules and the Act.

Based on her review of the Board’s rules and the Act as in effect during the time period at issue, Ms. Cone developed a recommended sanction. Specifically, she noted that on Charge I, a nurse calling in absent after a shift has started is a serious lapse, because patient assignments have already been made and vulnerable patients could be placed at greater risk if adequate coverage cannot be provided. Additionally, it is a violation for a nurse to accept an assignment that she is not qualified or physically able to handle for any reason.

With respect to Charge II, Ms. Cone argued that the positive drug screen for methadone indicated intemperate use of methadone, and echoed Ms. Leal’s testimony that Ms. Tomlinson’s prescription was for a high dose of methadone. The intemperate use of a drug that could affect a nurse’s ability to act or react while on duty is a violation. Since the July 25, 2006 meeting occurred during Ms. Tomlinson’s regular shift and the drug test was administered immediately

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<sup>18</sup> Resp. Ex. 9.

<sup>19</sup> Ms. Cone’s curriculum vitae is presented in State’s Ex. 9.

thereafter, Ms. Cone determined that Ms. Tomlinson had taken an assignment on that date, and testing positive constituted a violation.

By far the most serious charge, Ms. Cone noted, is Ms. Tomlinson's behavior on the morning of August 3, 2006. Ms. Tomlinson's actions on that day put patients at risk, and caused harm to J.L. J.L.'s fearful expression indicated that he was under stress, which can be especially dangerous for a vulnerable dialysis patient, and the blood spill and excess saline indicate that his health was put at risk. Ms. Cone noted that under the Board's rules and the Act, patient safety is paramount. The Board focuses on whether a nurse is fit or unfit to practice, regardless of whether the nurse's unfitness is caused by, e.g., alcohol addiction, use of illegal drugs, side effects of legally prescribed drugs, or illness.

Ms. Cone considered the factors set forth at 22 TEX. ADMIN. CODE § 213.33(c) in forming her recommendation, as well as the Board's matrix of penalty provisions found at 22 TEX. ADMIN. CODE § 213.33(b). She recommends that Ms. Tomlinson be fined \$250, ordered to pay Board costs, and be issued a reprimand with the following stipulations: attending a nursing jurisprudence class, notifying her current employer, general supervision, submission of performance evaluations, abstinence from drugs, drug screening, and a pain management program or other treatment program.

#### IV. ANALYSIS AND RECOMMENDATION

##### A. Staff's Charges

*Charge I.* Staff failed to prove the basis for sanction related to this charge. Ms. Cone testified that her recommendation for sanction rested on Ms. Green's July 27, 2006 memorandum stating that Ms. Tomlinson had left a "bizarre message on my voice mail" on June 24, 2006, and that she "made this call after the shift had started."<sup>20</sup> Ms. Green's testimony was inconsistent on this point. She testified that she *received* the voicemail after the shift had

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<sup>20</sup> State's Ex. 6 at 30.

started that day, but could not recall with certainty the time the voicemail was left. Other witnesses who heard the voicemail also could not confirm the time it was left.

The ALJ does not give credence to Ms. Tomlinson's assertion that the very fact she left a voicemail message proves that she called before the shift started. Liberty Dialysis staff may have been present but unable to answer the phone for a number of reasons. At the same time, there is no evidence to find with certainty that Ms. Tomlinson called *after* her shift had started, a key fact if sanctions are to be imposed. Staff therefore did not meet its burden to show that her actions on June 24, 2006 are sufficient to subject Ms. Tomlinson to sanction under Act §§ 301.452(b)(10), (12) or (13), or Board Rules 217.11(1)(T), 217.12(1)(E) or 217.12(5).

**Charge II.** Staff failed to prove the basis for sanction related to this charge. No party contested the authenticity or accuracy of the July 25, 2006 drug screening, which showed a positive result for methadone. Ms. Tomlinson herself confirmed that she was taking methadone under a prescription from Dr. Kikkeri.

However, a positive screen for a prescription medication is not in itself a violation. The statutory and regulatory provisions cited by Staff as the bases for sanction for this charge require some nexus between the alleged drug use and the nurse's practice. Specifically, Act § 301.452(b)(9) sanctions "*intemperate use of alcohol or drugs that the Board determines endangers or could endanger a patient.*"<sup>21</sup> Board Rules 217.12(5) and 217.12(10)(A) are invoked if a nurse demonstrates "*actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals . . . or as a result of any mental or physical condition*" or if a nurse is using "*any controlled substance or any drug, prescribed or unprescribed, or device or alcoholic beverages while on duty or on call and to the extent that such use may impair the nurse's ability to safely conduct*" the practice of nursing.<sup>22</sup>

Methadone can cause a variety of side effects, as detailed by Dr. Kikkeri. It is established that on the day of the drug test, Ms. Tomlinson was scheduled to work and had

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<sup>21</sup> Emphasis added.

<sup>22</sup> Emphasis added.

reported for duty. However, there is no evidence that on that date, her use of methadone was "intemperate" or put a patient at risk, or that her ability to safely practice nursing was impaired.

Ms. Leal and Ms. Cone argued that Ms. Tomlinson's daily dose of methadone was "high" based on the Drug Guide. More reliable and relevant than the Drug Guide is the testimony of Dr. Kikkeri, who is a licensed physician with expertise in pain management, and who actually treated Ms. Tomlinson. Dr. Kikkeri described Ms. Tomlinson's prescription as being a "low to medium" dose for a patient who had previously taken narcotic medications. Admittedly, Dr. Kikkeri did not have access to Ms. Tomlinson's records, so he could not verify that she had previously taken narcotic medication, but he testified that he prescribes methadone only when he believes it necessary, and not as a first resort. Ms. Tomlinson herself testified that prior to starting methadone, she had taken oxycodone, another narcotic pain medication. Without access to Ms. Tomlinson's records, Dr. Kikkeri could not confirm that he had prepared a pain management plan and conducted regular drug screens for Ms. Tomlinson, but he testified that such procedures are his regular practice. Dr. Kikkeri's testimony was credible and there is no reason to believe he did not follow his usual practice in Ms. Tomlinson's case.

Further, the medication log maintained by Dr. Kikkeri verifies that Ms. Tomlinson was written a monthly prescription for methadone from January to July 2006. Though methadone can cause side effects such as impaired judgment, Dr. Kikkeri would not expect to see side effects suddenly appear in a patient who had been tolerating the drug for "a year or so." Ms. Tomlinson had been taking methadone since January 2006, but no unusual behavior was reported by Liberty Dialysis staff until June 2006. A six-month period of methadone use without discernible side effects is not conclusive, but weighs against a finding that methadone impaired Ms. Tomlinson's fitness as a nurse on July 25, 2006.

Staff included in Charge II a citation to Act § 301.452(b)(10), which sanctions "unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public." Ms. Cone suggested that Ms. Tomlinson's failure to notify Liberty Dialysis staff of her methadone prescription violated the facility's policies on drug use, and cited Ms. Tomlinson's alleged absenteeism as another instance of unprofessionalism.

The exact violation of Liberty Dialysis policy was not established, and the evidence of absenteeism was mixed. However, the ALJ does not reach these issues. Charge II, as pled, relates to impairment caused by the "intemperate use of methadone by a registered nurse while subject to call or duty," and does not extend to general aspects of professional behavior. For these various reasons, Staff failed to carry its burden as to Charge II.

*Charge III.* The testimony and evidence was unclear on some points with respect to the events of August 3, 2006.<sup>23</sup> However, Staff proved by a preponderance of the evidence that on August 3, 2006, Ms. Tomlinson lacked fitness to practice professional nursing. On that morning, she exhibited behavior inconsistent with what a prudent nurse would do, and that put a patient at risk. She failed to engage a safety mechanism on the dialyzer that resulted in a significant blood spill, frightened a vulnerable patient, and infused an excess amount of saline into an asymptomatic patient. In addition, Ms. Tomlinson exhibited slurred speech, a slow response or lack of response to questions and directions, shaking hands, glazed eyes, and stumbling and unsteady gait.

There is no evidence of what exactly is to blame for Ms. Tomlinson's behavior.<sup>24</sup> All of the witnesses agreed that Ms. Tomlinson generally was a good nurse and diligent in performing her job, and that the events of August 3, 2006, were very much out of character for her. However, as Ms. Cone correctly observed, the Act and the Board's rules prioritize patient safety and do not distinguish the reason for a nurse's lack of fitness to practice. Ms. Tomlinson repeatedly noted at hearing if she truly had been in such a dire condition, medical attention should have been summoned for her rather than a ride home. She asserted that the failure of Liberty Dialysis staff to obtain medical care for her supports her contention that she could not have been seriously impaired, or else it shows that they were not acting prudently.

While it may be reasonable and professionally advisable for colleagues to obtain medical attention for a co-worker who appears to be ill, Ms. Tomlinson's allegations of imprudence are

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<sup>23</sup> For example, the witness testimony differed with respect to who, if anyone, led Ms. Tomlinson away from the treatment area after the blood spill, which staff members subsequently attended to patients, and when Ms. Green arrived at the facility.

<sup>24</sup> The ALJ notes that intemperate use of methadone is not asserted to have been at issue on August 3, 2006, nor was a credible evidentiary link drawn between Ms. Tomlinson's use of methadone and her behavior on that date.

misplaced. Liberty Dialysis staff had a legal and ethical obligation to behave prudently with respect to the patients in their care, and Ms. Tomlinson was not a patient. Thus, the staff's failure to send Ms. Tomlinson for medical attention may have been inadvisable under the circumstances, but it is not relevant to this proceeding.

Ms. Tomlinson's explanation that she was just very tired, or alternatively that she was experiencing some illness that accounted for her behavior, is not supported by the evidence. At a minimum, she should not have accepted the assignment that day if she knew that she had been "up all night moving" residences, and reasonably would not be able to provide competent patient care the next morning. The behavior described by the witnesses is also not typical of a "very tired" person. As Dr. Kikkeri testified, the symptoms of slurred speech, unsteady gait and altered mental status could indicate a number of diseases or disorders. None of those diseases or disorders were shown to have affected Ms. Tomlinson. Most important is that the evidence demonstrates Ms. Tomlinson's lack of fitness to practice nursing on that day, regardless of the cause, which is sufficient to find a violation under the Act and Board rules.<sup>25</sup>

## **B. Sanction**

Staff seeks a two-year order against Ms. Tomlinson that requires a fine, imposition of costs, reprimand and stipulations described by Ms. Cone. Ms. Cone testified that her recommended sanctions were based on the three Charges taken as a whole. Since the ALJ finds Staff failed to meet its burden on two of the Charges, the ALJ looks to the Board's penalty matrix to determine the appropriate sanction for Charge III. Under the matrix, Ms. Tomlinson's conduct is: a second tier violation of Act § 301.452(b)(10) due to the serious risk to patient safety; a second tier violation of Act § 301.452(b)(12) due to the lack of fitness displayed; and a second tier violation of Act § 301.452(b)(13) due to the patient harm shown. Ms. Tomlinson also violated Board Rules 217.11(1)(T), 217.12(1)(E) and 217.12(5) for accepting an assignment that was not commensurate with her physical and emotional ability at the time and reasonably

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<sup>25</sup> The ALJ finds violations of Act §§ 301.452(b)(10), (12) and (13), and Board Rules 217.11(1)(T) and 217.12(1)(E) and (5), as discussed below.

could be expected to result in unsafe or ineffective care, and for the demonstration of an inability to practice with reasonable skill by reason of a mental or physical condition.

The Act and the Board's matrix require consideration of aggravating and mitigating factors. In this case, the ALJ finds it especially troubling that Ms. Tomlinson refuses to admit in any way that her actions on August 3, 2006 were inconsistent with prudent nursing practice, displayed a lack of fitness, and caused harm to a patient. The deterrent effect of a fine and reprimand is advisable under these circumstances. On the other hand, it is in Ms. Tomlinson's favor that she otherwise has a clean record, including in the nearly four years since the events at issue.

In addition to disciplinary sanctions, the Board is authorized to impose administrative penalties and to "assess a person who is found to have violated [the Act] the administrative costs of conducting a hearing to determine the violation."<sup>26</sup> Staff submitted an affidavit of administrative costs totaling \$1,819.00.<sup>27</sup> After reviewing the supporting documentation submitted by Staff, as well as Ms. Tomlinson's arguments as to the validity of such costs, the ALJ finds that Staff has established the reasonableness and necessity of the \$1,819.00 sought.

Based on the Board's matrix, the ALJ recommends: a fine of \$250.00; imposition of Board costs of \$1,819.00; a reprimand and completion of a nursing jurisprudence class (or other educational program deemed acceptable by the Board); and notification of the Board's order to Ms. Tomlinson's current employer. Ms. Tomlinson's unfitness to practice on August 3, 2006 was not shown to be caused by or linked to her prescription use of methadone. There is no evidence of subsequent events indicating intemperate use of drugs or alcohol or other physical or mental conditions that could impair Ms. Tomlinson's ability to practice as a nurse. Under these circumstances, the ALJ does not find supervised practice, mandatory drug testing, or a pain management or treatment program to be appropriate.

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<sup>26</sup> Act § 301.461.

<sup>27</sup> State's Ex. 10. The exhibit included a charge of \$140.00 for the first two hours of court reporting fees on the second day of hearing, and indicated that the final cost of such services would be determined by the duration of the hearing. At the conclusion of the hearing on April 9, 2010, the court reporter verified to the ALJ that the additional reporting costs were \$385.00 (\$70.00 x 5.5 hours). The addition of \$385.00 to Staff's preliminary total of \$1,434.00 results in a total cost to the Board of \$1,819.00.

### V. FINDINGS OF FACT

1. Peggy Ann Tomlinson holds permanent certificate number 720058 issued by the Texas Board of Nursing (Board) in August 2005.
2. On February 4, 2010, Board staff (Staff) sent its First Amended Notice of Hearing to Ms. Tomlinson by certified mail. The notice was received on February 8, 2010.
3. 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.
4. Administrative Law Judge (ALJ) Pratibha J. Shenoy convened the hearing on the merits on March 18 and April 9, 2010, at the State Office of Administrative Hearings (SOAH), William P. Clements Office Building, 300 West 15<sup>th</sup> Street, Austin, Texas.
5. Assistant General Counsel Jena Abel represented Staff. Ms. Tomlinson appeared *pro se*, assisted by her husband, Kevin Tomlinson. Ms. Tomlinson participated in person on the first day of hearing, and telephonically on the second day.
6. The record closed on April 16, 2010.
7. Ms. Tomlinson began working at an outpatient dialysis center, Liberty Dialysis in Lancaster, Texas, in September 2005.
8. On June 24, 2006, Ms. Tomlinson called in sick to work, leaving a voicemail message for Sherry Green, the facility administrator.
9. Staff failed to establish that Ms. Tomlinson recorded the voicemail message only after her scheduled shift had begun that day.
10. On July 25, 2010, Ms. Tomlinson completed a drug screen ordered by Liberty Dialysis.
11. The drug screen reflected a positive test for methadone, a controlled substance.
12. Ms. Tomlinson was taking methadone under a valid prescription from her treating physician.
13. Staff failed to establish that Ms. Tomlinson's use of methadone was intemperate.
14. Staff failed to establish impairment at work or any effect on Ms. Tomlinson's practice or on her patients as a result of her methadone use on July 25, 2006.

15. On August 3, 2006, while on duty at Liberty Dialysis, Ms. Tomlinson exhibited slurred speech, a slow response or lack of response to questions and directions, shaking hands, glazed eyes, and stumbling and unsteady gait.
16. On August 3, 2006, Ms. Tomlinson operated a dialysis machine without engaging a safety mechanism, resulting in a significant blood spill, distress and risk to the health of an already vulnerable patient, and an excess infusion of saline into an asymptomatic patient.
17. Ms. Tomlinson has had no previous disciplinary actions brought against her by the Board.
18. There is no evidence of allegations of misconduct by Ms. Tomlinson, or disciplinary action against her nursing license, subsequent to the events of June-August 2006.
19. Staff incurred \$1,819.00 in reasonable and necessary administrative costs of the hearing in this matter.

## VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. TEX. OCC. CODE ch. 301.
2. SOAH 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. TEX. GOV'T CODE ch. 2003.
3. Proper and timely notice of the hearing was provided. TEX. GOV'T CODE ch. 2001; 22 TEX. ADMIN. CODE § 213.10.
4. A nurse is subject to discipline for:
  - a. unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public. TEX. OCC. CODE § 301.452(b)(10);
  - b. lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public. TEX. OCC. CODE § 301.452(b)(12);
  - c. failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm. TEX. OCC. CODE § 301.452(b)(13);

- d. failure to accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability; 22 TEX. ADMIN. CODE § 217.11(1)(T);
  - e. accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care. 22 TEX. ADMIN. CODE § 217.12(1)(E); and
  - f. demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition. 22 TEX. ADMIN. CODE § 217.12(5).
5. Based on the Findings of Fact, on August 3, 2006, Ms. Tomlinson violated TEX. OCC. CODE §§ 301.452(b)(10), 301.452(b)(12) and 301.452(b)(13), and 22 TEX. ADMIN. CODE §§ 217.11(1)(T), 217.12(1)(E) and 217.12(5).
  6. The foregoing Findings of Fact and Conclusions of Law indicate that the Board is authorized to sanction Ms. Tomlinson.
  7. Under the Board's penalty matrix found at 22 TEX. ADMIN. CODE §213.33(b), the behavior exhibited by Ms. Tomlinson warrants a fine and a warning or reprimand with various stipulations.
  8. The Board is authorized to assess a person who is found to have violated the Nursing Practice Act, TEX. OCC. CODE ch. 301 *et seq.*, the administrative costs of conducting a hearing to determine the violation. TEX. OCC. CODE § 301.461.
  9. Factors to be used by SOAH when recommending a sanction are set forth at 22 TEX. ADMIN. CODE §213.33(c).
  10. Based on the Findings of Fact and Conclusions of Law set forth herein, the Board should order that Ms. Tomlinson pay a fine of \$250.00 and Board costs of \$1,819.00. The Board should further order that Ms. Tomlinson be reprimanded and that she complete a nursing jurisprudence class or other educational program deemed acceptable by the Board. Finally, the Board should order that Ms. Tomlinson's current employer receive notification of the Board's Order.

SIGNED June 15, 2010.

  
PRATIBHA J. SHENOY  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS