BEFORE THE TEXAS BOARD OF NURSING

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

In the Matter of Registered Nurse	§	AGREED
License Number 510065	§	
issued to JAN E. BROWN	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Bo produced evidence indicating that JAN E. BROWN, hereinafter referred to as Responde Registered Nurse License Number 510065, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on June 15, 2010, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was notified of her right to be represented by legal counsel. Respondent was represented by Elizabeth L. Higginbotham, Attorney at Law. In attendance were Mary Beth Thomas, PhD, RN, Director of Nursing Education, Executive Director's Designee; John F. Legris, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Soraya Trammell, Administrative Technician and Nancy Krause, RN, Investigator.

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 notice and hearing, and consented to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Tarelton State University, Stephenville, Texas, on May 1, 1983. Respondent was licensed to practice professional nursing in the State of Texas on August 30, 1983.

5. Respondent's nursing employment history includes:

1983 - 1985	Staff Nurse	Brownwood Regional Hospital Brownwood, Texas
10/86 - 3/99	Director of Nurses Home Health	Brown County Visiting Nurses Brownwood, Texas
1990 - 1991	Staff Nurse Orthopedics; Med/Surg	Humana Hospital Abilene, Texas
1991 - 1992	Staff Nurse	Hendricks Hospital of Abilene Abilene, Texas
1992 - 1993	Staff Nurse Orthopedics; Med/Surg	HCA Medical Center fo Ft. Worth Ft. Worth, Texas
1993 - 2000	Unknown	
2/2000 - 7/2001	Staff Nurse Post-Op, Orthopedics	St. David's Medical Center Austin, Texas
7/2000 - 9/2003	Agency Nurse	Maxim Health Care Austin, Texas
7/2001 - 5/2002	Staff Nurse Labor and Delivery	North Austin Medical Center Austin, Texas
5/2002 - 11/2002	Staff Nurse	Fort Hood Hospital Killeen, Texas
12/2002	Unknown	
1/2003 - 1/2008	Staff Nurse Med/Surg	Round Rock Medical Center Round Rock, Texas
2/2008 - 4/2008	Unknown	

Respondent's professional nursing employment continued:

5/2008 - 8/2008	Charge Nurse	Hearthstone Medical Center-Rehab Round Rock, Texas
9/2008 - 10/2008	Unknown	
11/2008 - Present	Staff/Charge Nurse	Cedar Park Regional Medical Center Cedar Park, Texas

6. On or about November 14, 2000, Respondent's license to practice professional nursing in the State of Texas was issued the sanction of Reprimand with Stipulations through an Order by the Board of Nurse Examiners for the State of Texas A copy of the November 14, 2000, Order of the Board, Staff's Proposed Sanctions and Stipulations, and Proposal for Decision is attached and incorporated, by reference, as part of this Order.

7. On or about October 19, 2006, Respondent's license to practice professional nursing in the State of Texas was issued the sanction of Suspend/Probate through an Agreed Order by the Board of Nurse Examiners for the State of Texas. A copy of the October 19, 2006, Agreed Order, Findings of Fact and Conclusions of Law is s attached and incorporated , by reference, as part of this Order.

8. At the time of the initial incident in Finding of Fact Number Nine (9), Respondent was employed as a Staff Nurse with Saint David's Round Rock Medical Center, Round Rock, Texas, and had been in this position for three (3) years and one (1) month.

9. On or about February 18, 2006, while employed as a Staff Nurse with Saint David's Round Rock Medical Center, Round Rock, Texas, Respondent failed to notify the physician that Patient #58349 had fallen on the floor and sustained a scalp hematoma after Respondent found the patient lying on the floor with a skin tear noted to the left middle finger and a bump on the head, pink and purple in color and tender to touch. Respondent's conduct was likely to cause injury to the patient in that the physician was deprived of essential information necessary to initiate timely medical intervention to stabilize the patient and prevent possible further complications.

10. In response to the incident in Finding of Fact Number Ten (10), Respondent states the patient was confused after experiencing a Cerebral Vascular Accident resulting in weakness on the right side. Respondent indicates that she and one aide were assigned to care for thirty-six (36) patients on the unit, of which five (5) were total care patients. Patient #58349 was on fall precautions and was occasionally combative. The patient did have a roll belt on and it was found in the bed when the patient got out of bed and fell. Respondent states she did assess the patient immediately and continued to assess her throughout the night. The charge nurse also came and assessed the patient and agreed that the physician did not need to be called. Respondent states she did write the physician a note letting him know the patient had fallen. The patient had been placed on Coumadin earlier in the day and it was not on the Medication Administration Record, nor had it been communicated during shift report. Respondent contends that if she had been aware the patient was taking Coumadin, she would have contacted the physician.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code,and22 TEX. ADMIN. CODE §217.11(1)(B)&(1)(D) and 22 TEX. ADMIN. CODE §217.12(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 510065, heretofore issued to JAN E. BROWN, including revocation of Respondent's license to practice professional 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 multistate licensure privilege, if any, to practice nursing in compact states.

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 multistate licensure 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 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://www.learningext.com/products/generalce/critical/ctabout.asp.*

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) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(3) 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.

(4) 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.

(5) 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.

(6) 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 and RESPONDENT shall be eligible for multistate licensure privileges, if any, to practice nursing in the State of Texas.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

RESPONDENT'S CERTIFICATION

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

Signed this 16th day of July, 2010.

Jan E. Brown

JAN E. BROWN, Respondent

Sworn to and subscribed before me this 16 day of July, 2010.

SEAL

SABRINA P. JACKSON
MY COMMISSION EXPIRES
July 24, 2011

Sabrina P. Jackson

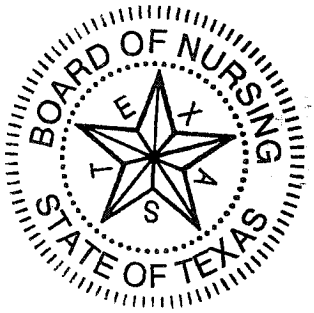
Notary Public in and for the State of Texas

Approved as to form and substance.

Elizabeth L. Higginbotham, Attorney for Respondent

Signed this 20th day of July, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 16th day of July, 2010, by JAN E. BROWN, Registered Nurse License Number 510065, and said Order is final.



Effective this 17th day of August, 2010.

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

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS
****

In the Matter of Registered Nurse	§	AGREED
License Number 510065	§	
issued to JAN E. BROWN	§	ORDER

On this day the Board of Nurse Examiners for the State of Texas, hereinafter referred to as the Board, considered the matter of JAN E. BROWN, Registered Nurse License Number 510065, 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 conference, notice and hearing, and agreed to the entry of this Order offered on September 10, 2006, 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 conference, 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.

4. Respondent received an Associate Degree in Nursing from Tarleton State University, Stephenville, Texas, in May 1983. Respondent was licensed to practice professional nursing in the State of Texas on August 30, 1983.

5. Respondent's professional nursing employment history includes:

8/83 - 9/86	Assistant Head Nurse Orthopedics	Brownwood Regional Hospital Brownwood, Texas

Respondent's professional nursing employment history includes:

10/86 - 3/99	Director of Nurses Home Health	Brown County Visiting Nurses Brownwood, Texas
1990 - 1993	Staff Nurse Orthopedics; Med/Surg	Humana Hospital Abilene, Texas
1993 - 1994	Staff Nurse	Hendricks Hospital of Abilene Abilene, Texas
1994 - 1996	Staff Nurse Orthopedics; Med/Surg	HCA Medical Center of Ft. Worth Ft. Worth, Texas
7/00 - 9/03	Agency Nurse	Maxim Health Care Austin, Texas
10/01 - 6/02	Staff Nurse Post-OP; Orthopedics	St. David's Medical Center Austin, Texas
7/02 - 3/03	Staff Nurse Labor and Delivery	North Austin Medical Center Austin, Texas
4/03 - 9/03	Agency Nurse	Arora Group Killeen, Texas
10/03 - Present	Staff Nurse Med/Surg	Round Rock Medical Center Round Rock, Texas

6. On or about November 14, 2000, Respondent's license to practice professional nursing in the State of Texas was issued the sanction of Reprimand with Stipulations through an Order of the Board. A copy of the Order of the Board, Staff's Proposed Sanctions and Stipulations, and Proposal for Decision is attached and incorporated herein by reference.

7. At the time of the incident in Finding of Fact Number Eight (8), Respondent was employed as a Staff Nurse on the Medical/Surgical Unit with Round Rock Medical Center, Round Rock, Texas, and had been in this position for one (1) year and five (5) months.

8. On or about March 13, 2005, while employed with Round Rock Medical Center, Round Rock, Texas, Respondent failed to provide adequate care for Patient Medical Record Number 118085 in that she failed to initiate CPR when the patient was found unresponsive and pulseless. Patient Medical Record Number 118085 was a 93-year-old patient who was admitted with atypical chest pain and aggressive behavior secondary to end-stage dementia with psychosis. The patient was in the hospital less than 24 hours before she expired.

9. In response to the incident in Finding of Fact Number Eight (8), Respondent states that this patient had had multiple admissions during the previous month and she thought the admission were the same person that she had cared for before. The patient had been admitted February 11, 2005, through February 13, 2005, and the code status for this admission was "AND-I" (Allow Natural Death with Intermediate Interventions); the second admission was February 19, 2005, through February 21, 2005, with no code status documented; and the last admission was March 12, 2005, through March 13, 2005, with "no code status on chart, and no form for code status in chart and patient was hospitalized less than 24 hours.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A)&(1)(M) and 217.12(1)(B),(4)&(6)(C).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against License Number 510065, heretofore issued to JAN E. BROWN, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Board of Nurse Examiners, that Registered Nurse License Number 510065, previously issued to JAN E. BROWN, to practice professional nursing in Texas is hereby SUSPENDED for a period of two (2) years with the suspension STAYED and Respondent is hereby placed on PROBATION for two (2) years with the following agreed terms of probation:

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, if any, to practice professional nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is

encumbered by this order the Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq.* and this Order.

(2) RESPONDENT SHALL deliver the wallet-sized license issued to JAN E. BROWN, to the office of the Board of Nurse Examiners within ten (10) days of the date of this Order for appropriate notation.

(3) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in Texas nursing jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is <u>not</u> 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) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. 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 on the Board's website, <u>www.bne.state.tx.us</u> (under BNE events).*

(4) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in nursing 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. The course shall be a minimum of six (6) contact hours in length. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: principles of nursing ethics; confidentiality; and professional boundaries. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to verify RESPONDENT's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(5) RESPONDENT SHALL, within sixty (60) days of the suspension being stayed, successfully complete a course in Basic Cardiopulmonary Life Support for Healthcare Providers. RESPONDENT SHALL obtain Board approval of the course and instructor prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The course shall be a minimum of eight (8) contact hours in length. The course's content shall include: Adult, Infant, and Child 1- and 2-Rescuer CPR; Adult, Infant, and Child Foreign Body Airy Obstruction for both responsive and unresponsive victims; and Adult Automated External Defibrillation. In order to receive credit for completion of this workshop, RESPONDENT SHALL obtain the Verification of Course Completion form from the Board's website, ftp://www.bne.state.tx.us/i17.pdf, and SHALL SUBMIT the Verification of Course Completion form to the Board's office, to the attention of Monitoring, after having the form completed and signed by the course instructor. RESPONDENT

SHALL also submit a front and back copy of the course completion card along with the Verification of Course Completion form. 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.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A REGISTERED 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 PROBATION CONDITIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY 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 PROBATIONARY PERIOD:

(6) RESPONDENT SHALL notify each present employer in professional nursing of this Order of the Board and the probation conditions 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 professional nursing of this Order of the Board and the probation conditions 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.

(7) 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.

(8) 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 professional 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) months for two (2) years of employment as a professional nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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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 violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 19 day of October, 20 06.

Jan E. Brown

JAN E. BROWN, Respondent

Sworn to and subscribed before me this 19 day of October, 20 06.

C. Alviar

SEAL

CARIN ALVIAR
Notary Public, State of Texas
My Commission Expires
January 25, 2009

Notary Public in and for the State of TX

WHEREFORE, PREMISES CONSIDERED, the Board of Nurse Exam 19th day of October, 20 06, by JAN E. BROWN, Registered Nurse License Number 510065, and said Order is final.

Effective this 13th day of November, 20 06.

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

DOCKET NO. 507-00-1226

IN THE MATTER OF	§	BOARD OF NURSE EXAMINERS
PERMANENT CERTIFICATE	§	
NUMBER 510065	§	
ISSUED TO	§	
JAN E. BROWN	§	FOR THE STATE OF TEXAS

ORDER OF THE BOARD

TO: JAN E. BROWN
4206 ELMGROVE CRT.
ARLINGTON, TX 76015

During open meeting at Austin, Texas, the Board of Nurse Examiners finds that after proper and timely notice was given, the above-styled case was heard by an Administrative Law Judge who made and filed a proposal for decision containing the Administrative Law Judge's findings of fact and conclusions of law. The proposal for decision was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein.

The Board of Nurse Examiners, after review and due consideration of the proposal for decision, and exceptions and replies filed, if any, adopts the findings of fact and conclusions of law of the Administrative Law Judge as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that the License Number 510065 previously issued to JAN E. BROWN to practice professional nursing in the State of Texas be, and the same is hereby, reprimanded for one-year with stipulations. As set forth in the document attached hereto as Exhibit "A".

DOCKET NUMBER 507-00-1226

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 510065	§	OF
ISSUED TO	§	
JAN E. BROWN	§	ADMINISTRATIVE HEARINGS

STAFF'S PROPOSED SANCTIONS AND STIPULATIONS

RESPONDENT SHALL receive the sanction of a Reprimand with Stipulations and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas, as amended, Article 4513 et seq., the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 Texas Administrative Code §217.01 et seq., and this Order.

IT IS FURTHER ORDERED that RESPONDENT SHALL comply with the following stipulations:

(1) RESPONDENT SHALL deliver the wallet-size license, issued to JAN E. BROWN, to the office of the Board within ten (10) days of the date of this Order for appropriate notation.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience must include registered nurses. It must be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. 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 is to be taken in addition to any continuing education requirements the Board may have for relicensure.

EXHIBIT A

(3) 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. Home study courses and video programs will not be approved. The course must be a minimum of six (6) hours in length. In order for the course to be approved, the target audience must include registered nurses. The course must contain content on the following: guidelines and processes for good reporting and recording; legal guidelines for recording; methods 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 is to be taken in addition to any continuing education requirements the Board has for relicensure.

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing ethics to include professional boundaries. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. The course must be a minimum of six (6) contact hours in length. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to verify RESPONDENT'S successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure.

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CONTINUED ON NEXT PAGE.

IT IS FURTHER ORDERED, SHOULD RESPONDENT CHOOSE TO PRACTICE AS A REGISTERED NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL PRACTICE SETTING, UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT:

(5) RESPONDENT SHALL notify each present employer in professional nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a copy of this Order to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in professional nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a copy of this Order to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in professional nursing to submit the Notification of Employment form, which is provided 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 to the Board's office within five (5) days of employment as a professional nurse.

(7) RESPONDENT SHALL be supervised by a registered nurse who is on the premises. The supervising RN 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. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, 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 by the Board, periodic reports as to RESPONDENT's capability to practice professional nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted to the office of the Board at the end of each three (3) months for one year(s) of employment as a professional nurse.

IT IS FURTHER ORDERED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license to practice professional nursing in the State of Texas.

IT IS, FURTHER, ORDERED that Permanent Certificate Number 510065 previously issued to JAN E. BROWN, upon receipt of this Order, be immediately delivered to the office of the Board of Nurse Examiners for the State of Texas.

Entered this 14th day of November, 2000.

BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

BY: Katherine A. Thomas
Katherine A. Thomas, M.N., R.N.
Executive Director on behalf of said Board

DOCKET NO. 507-00-1226

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
	§	
PERMANENT CERTIFICATE ISSUED	§	OF
TO JAN E. BROWN	§	
CERTIFICATE NO. 510065	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The Staff of the Board of Nurse Examiners (Staff or Board) brought disciplinary action against Jan E. Brown, R.N. (Respondent), and requested Respondent be issued a reprimand with stipulations for one year. The Staff alleged that Respondent committed various violations of the Nursing Practice Act (Act), TEX. REV. CIV. STAT. ANN. arts. 4513-4528,[1] and of Board rules implementing the Act. After hearing the evidence, the Administrative Law Judge recommends that Respondent receive from the Board a one-year reprimand with stipulations.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

On August 10, 2000, a hearing was convened before Michael J. Borkland, Administrative Law Judge, in the Stephen F. Austin Building, 1700 North Congress, 11th Floor, Suite 1100, Austin, Texas. James W. "Dusty" Johnston, Board General Counsel, represented Staff. Respondent appeared *pro se*. The record was closed at the conclusion of the hearing.

There are no contested issues of notice or jurisdiction in this proceeding. Therefore, those matters are set out in the proposed Findings of Fact and Conclusions of Law without further discussion here.

II. DISCUSSION

A. Background.

Respondent was licensed by the State of Texas in 1983 as a registered nurse (RN). In 1987 she opened a home health agency, Brown County Visiting Nurses, Inc., in Early, Texas. In 1995, Respondent moved approximately 140 miles from Early to Arlington, Texas. However, she remained as the supervising RN for the home health agency. She sold her business in 1999 following an audit by the Texas Department of Health.

B. Formal Charges.

On February 18, 2000, Staff filed charges against Petitioner alleging:

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[1]Now within the TEXAS OCCUPATION CODE.

CHARGE I.

Between June 1998 and December 1998, while employed as the Administrator with Brown County Visiting Nurses, Early, Texas, Respondent directed and allowed a licensed vocational nurse and an unlicensed staff member to complete documentation regarding skilled nursing visits they did not actually perform on patients O.W., E.A., T.S., and S.E. and to sign her name to these documents. Respondent's conduct could have resulted in inaccurate and inappropriate information being documented in these patients' clinical records. Staff relying on this information might have made inappropriate decisions regarding the care of these patients, thus unnecessarily exposing the patients to risk of harm.

The above action constitutes a violation of Article 4525(b)(12), TEX. REV. CIV. STAT. ANN., and 22 TEXAS ADMIN. CODE § 217.11 (17) & (16).

CHARGE II.

Between July 1998 and December 1998, while employed with the above mentioned agency, Respondent failed to perform and document supervisory aide visits on patients O.W., E.A., and S.E. at least every two (2) weeks as follows:

PATIENT	SUPERVISORY VISIT DUE DATES	SUPERVISORY AIDE DOCUMENTATION
O.W.	7/1/98; 8/1/98 through 8/31/98	None
E.A.	7/1/98 through 8/31/98; 12/15/98 through 12/31/98	None
S.E.	7/21/98 through 8/31/98	None

Respondent's omissions could have resulted in inappropriate or unsafe care being provided to agency patients, thus unnecessarily exposing patients to risk of harm.

The above action constitutes a violation of Article 4525(b)(12), TEX. REV. CIV. STAT. ANN., and 22 TEXAS ADMIN. CODE § 217.11(7) & (16).

C. *Legal Standards.*

The Act provided in part at Article 4525:

(b) The Board may take disciplinary action against a registered nurse for any of the following reasons:

(12) Failing to care adequately for patients or to conform to the minimum standards of acceptable professional nursing practice that, in the opinion of the Board, exposes a patient or other person unnecessarily to risk of harm.

Board rules provide:

1. 22 Texas Administrative Code (TAC) § 213.33. Penalty/Sanction Factors.

(a) The following factors shall be considered by the executive director when determining whether to dispose of a disciplinary case by fine or by fine and educational stipulation and the amount of such fine. These factors shall be used by the State Office of Administrative Hearings and the Board in determining the appropriate penalty/sanction in disciplinary cases:

(1) evidence of actual or potential harm to patients, clients or the public;

(2) evidence of a lack of truthfulness or trustworthiness;

(4) evidence of practice history;

(7) the length of time the licensee has practiced;

(9) the deterrent effect of the penalty imposed.

2. 22 TAC § 217.11. Standards of Professional Nursing Practice. The responsibility of the Texas Board of Nurse Examiners (board) is to regulate the practice of professional nursing within the State of Texas. The purpose of defining standards of practice is to identify roles and responsibilities of the registered professional nurse (RN) in any health care setting. The standards for professional nursing practice shall establish a minimum acceptable level of professional nursing practice. The RN shall:

(7) accurately report and document the client's symptoms, responses, and status;

(15) make assignments to others that take into consideration client safety and which are commensurate with educational preparation, experience, knowledge and ability of the persons to whom the assignments are made;

(16) supervise nursing care provided by others for whom the RN is administratively or professionally responsible.

3. 25 TAC § 115.21

(4) Client record. An agency shall establish and maintain a client record system to assure that the care and services provided to each client is completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information.

(G) Each entry to the client record shall be accurate, signed and dated with the date of entry by the individual making the entry. . . .

The Code of Federal Regulation (CFR) provides:

1. 42 CFR § 484.36

(d) Standard: Supervision. (1) If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d) (2) of this section. . . .

(2) The registered nurse . . . must make an on-site visit to the patient's home no less frequently than every 2 weeks.

2. 42 CFR § 484.12 Conditions of participation: Compliance with Federal, State, and local laws, disclosure and ownership information, and accepted professional standards and principles.

(c) Standard: Compliance with accepted professional standards and principles. The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.

D. Staff's Evidence.

Staff offered 14 exhibits and presented the testimony of several fact and expert witnesses.

1. Karen Burk, RN.

Ms. Burk obtained a Bachelor of Science Degree in Nursing from the University of Texas in 1987. She also holds a certification in home health nursing, and has worked for the Board for more than three years.

Ms. Burk investigated the written complaint filed against Respondent. She subpoenaed documents, interviewed witnesses, and reviewed evidence as part of her investigation into the complaint. She testified that Respondent has owned and operated Brown County Visiting Nurses, Inc. for 13 years. She further testified that Respondent changed her residence in 1995 from Early to Arlington, Texas, a distance of approximately 140 miles. She stated that there was not another RN on staff at the agency, and that a supervising RN should be available at all times.

Ms. Burk discussed the charges with Respondent during an interview. She testified that Respondent admitted that she directed and allowed her sister, an LVN, and mother, an unlicensed employee, to complete documentation and sign her name on various forms. Respondent told Ms. Burk that she saw nothing wrong with this because she trusted her mother and sister completely. Respondent also admitted that she was in the office in Early, Texas, only about four days per month.

Regarding Charge II, Ms. Burk testified that a supervisory visit in the home by an RN is required every 14 days for patients receiving home health aid services from a home health aid. She reviewed the work schedules (Exh. 8) of Brown County Visiting Nurses, Inc., other patient records

(Exhs. 9 and 10), and the survey completed by the Texas Department of Health (Exh. 11) to verify home supervisory visits and compliance with other rules and regulations. Ms. Burk testified that upon a review of the records, there is no documentation to show that supervisory visits were performed every 14 days as required. She further testified that this failure to make home visits places patients at risk of harm because the RN is not available for assessment patients, and to insure that there is not an inappropriate implementation of aid plans. Ms. Burk stated that one patient was actually harmed by the failure to make required supervisory visits because wounds on the patient's feet were not properly treated, leading to his eventual hospitalization.

2. Carla S. Johnston, RN.

Ms. Johnston obtained a Diploma in Nursing from Methodist Hospital, Lubbock, Texas, in 1975, and a Bachelor of Science Degree in Nursing from West Texas State University, Canyon, Texas, in 1980. Ms. Johnston has extensive experience in the home health field, practicing in the field as both a staff and supervisory nurse. In 1993, she opened a home health agency that remained in operation until 1999. Additionally, she worked for two years as a state surveyor with the Texas Department of Health (TDH) surveying home health agencies for compliance with state and federal law.

Ms. Johnston testified that a supervisory home health care nurse must live within 50 miles[2] of her patients in order to properly supervise the home health agency staff, and to assess patients for nursing intervention. She stated that direct observation of the patient is important for proper care.

Ms. Johnston further testified that she met Respondent in March 1999 when she was in Early to evaluate Brown County Health Care, Inc. for possible acquisition. In evaluating the agency, Ms. Johnston reviewed agency clinical and financial records, and the TDH Survey that had been completed in February 1999. TDH recommended the agency for 23-day termination, and Ms. Johnston had been instructed to validate the cited deficiencies, and to prepare and submit a plan of correction. She testified that the deficiencies were accurate, and that Respondent's plan of correction was unacceptable to TDH. Brown County Visiting Nurses, Inc. was cited for failing to provide a supervisory RN for agency personnel; allowing unlicensed personnel to provide care that was not supervised and evaluated; and allowing unlicensed persons to sign patient records. Ms. Johnston stated the deficiencies show that an RN did not provide the care that was documented in patient records.

Ms. Johnston also talked to agency staff, physicians' offices, and one patient, EA. Respondent's sister is a Licensed Vocational Nurse (LVN), and she worked for Respondent. During a conversation one day, the LVN was asked if Respondent would be in the office for purposes of signing paperwork. The LVN responded that she could sign it as she had been authorized by Respondent to sign Respondent's name to paperwork.

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[2]Both the witness and staff referred to this as the 50 mile rule. However, citation to an actual Board rule or other source was not provided.

Ms. Johnston also talked to physicians' offices to verify care plans. One physician told her that he had not seen the patient in two years and had not authorized the care that was being provided. Ms. Johnston stated that this corroborates the deficiency of an absentee RN.

Ms. Johnston also talked to patient EA when she performed a skilled nursing assessment. She had difficulty getting EA on the telephone, but was finally successful in doing so. She learned that EA had driven herself to the grocery store and beauty shop. She also learned that EA routinely left home without assistance by driving her car. EA did not meet home health care requirements because she was not homebound. Ms. Johnston also discovered that the clinical record plan of treatment did not reflect the current medications taken by EA.

Additionally, EA stated that an LVN came to her home and assisted her with house cleaning, that she had never met Respondent and did not know who she was. Ms. Johnston testified that EA's assessment should have been personally performed by an RN, not an LVN.

Ms. Johnston contacted the RN listed by Respondent as the alternate supervising RN to verify the deficiency that no alternate RN was available. The RN stated that she was not available to be the alternate supervising RN, and had not seen a patient for Respondent in several years.

3. Tammy Prine, RN.

Ms. Prine has worked in the home health field since 1989 as both a field nurse and administrator. She also worked for the company that acquired Respondent's agency. Her employer requested her, along with Ms. Johnston, to perform a clinical due diligence review of Respondent's agency for compliance with regulations.

Ms. Prine reviewed the survey performed by the TDH in February 1999. She found it unusual that the agency had been placed on the termination track because this meant that there had been a significant failure by the agency to comply with state and federal regulations. She pointed out that the agency was given 23 days to correct the violations. Ms. Prine found the survey to be accurate, and she and Ms. Johnston prepared corrections for implementation.

Ms. Prine also reviewed the charts of nine patients. She then conducted home visits to interview the patients and their families for nursing assessments. She found that only three of the nine patients were homebound, and thus qualified to remain on home health care. Patients OW and SE did not qualify because they were not homebound and did not need skilled nursing. Ms. Prine stated that an actively involved RN would have been aware of this.

Ms. Prine found that TS qualified for home health care because he had a medical need for a nurse, was homebound, and had physician authorization. Upon examination, Ms. Prine found that TS had wounds on his feet that had been present for a long period of time. Eventually, he had to be placed in a nursing home for treatment. She could not verify from the records the last time that the wounds had been assessed by an RN, and the patient and his family stated that they had never met Respondent. Ms. Prine stated that it is the job of a home health care RN to protect the public's health, and this was not done in TS's case.