



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

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 584603 and §
Vocational Nurse License Number 131270 §
issued to KIM ILINE SOTO § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of KIM ILINE SOTO, Registered Nurse License Number 584603 and Vocational Nurse License Number 131270, hereinafter referred to as Respondent.

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

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the licenses.
2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's license to practice vocational nursing in the State of Texas is currently in "delinquent" status.
4. Respondent received a Certificate in Practical Nursing from New Mexico Junior College, Hobbs, New Mexico, on August 26, 1990, and received an Associate Degree in Nursing from New Mexico Junior College, Hobbs, New Mexico, on May 8, 1992. Respondent was licensed to practice vocational nursing in the State of Texas on November 28, 1990, and was licensed to practice professional nursing in the State of Texas on August 31, 1992.

5. Respondent's nursing employment history includes:

11/1990 - 06/1992	Unknown	
07/1992 - 05/2001	Charge Nurse	Shannon Medical Center San Angelo, Texas
05/2001 - 09/2003	Staff Nurse	Shannon Memorial Hospital San Angelo, Texas
10/2003	Unknown	
11/2003 - 06/2005	Field Nurse	Girling Home Health San Angelo, Texas
07/2005 - 10/2005	Unknown	
11/2005 - Unknown	Charge Nurse	Meadow Creek Nursing Center San Angelo, Texas
07/2006 - Unknown	RN Case Manager	San Angelo State School Carlsbad, Texas

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a RN Case Manager with San Angelo State School, Carlsbad, Texas, and had been in this position for two (2) years and six (6) months.
7. On or about January 9, 2009, while employed as a RN Case Manager with San Angelo State School, Carlsbad, Texas, Respondent failed to perform a complete assessment of Client Number 5117, after he had been examined by the physician, who had ordered a narcotic pain medication, Fentanyl, for treatment of the client's arthritic hip pain. Respondent failed to obtain baseline vital signs, and failed to thoroughly assess the client's pain, including location, frequency, quality, and intensity of pain, precipitating factors, aggravating factors, the effect of pain on the clients' range of motion, and therapeutic measures that help relieve the client's pain. Respondent's conduct deprived care givers of information on which to base their care decisions.
8. On or about January 9, 2009, while employed as a RN Case Manager with San Angelo State School, Carlsbad, Texas, Respondent failed to timely and appropriately document in the medical record of the abovementioned Client Number 5117 regarding the training she provided concerning the change in treatment plan and the new medication, Fentanyl. The treatment plan Respondent initiated lacked specifics regarding frequency of pain assessment, responsibility for assessment of pain, frequency of vital signs, frequency of assessment for

side effects, responsibility for the assessments, whether by the nurses or unlicensed direct care staff, who reported to the Social Services Department, and to whom any side effects should be reported. The plan also did not include specific measures to protect the affected joint. The information for the Fentanyl patch was printed on the back of the Training Roster and contained information including the common side effects and severe side effects to report. The client had a diagnosis of seizure disorder, and one of the side effects of Fentanyl was listed as seizures; however, there was no specific information regarding signs and symptoms of seizures or monitoring for same. The Training Roster, which was left for staff to read, did not include the name of the client. Client 5117 was found unresponsive, with vomitus around his mouth, and was pronounced deceased in the early morning hours of January 11, 2009. Respondent's conduct resulted in an inaccurate, incomplete medical record and was likely to injure the patient in that subsequent care givers would rely on her documentation in order to provide adequate patient care.

9. In response to the incident in Finding of Fact Number Eight (8), Respondent admits that she did not document information regarding Client Number 5117 on the 24 Hour Sheet and states that the evening shift and night shift Campus Shift RNs typed up the information on their 24 hour Report Sheets regarding the Fentanyl patch and initiation of the training with direct care staff. According to Respondent, she did give a verbal report to the evening shift RNs that training for the Fentanyl Patch was initiated with direct care staff and that a verbal training was completed with the 6-2 shift LVN assigned on January 9, 2009. Respondent explains that this was on a Friday and she was not to return until the following Monday. Respondent states that since the incident, she has had extensive education and training with the Nurse Educator, and she has improved the personalization of her care plans, which are quite individualized. Respondent concludes that she is saddened by the death of the client.
10. The Board finds that in response to the incident, the facility reviewed current Policies and Procedures, determined that they were not clear and specific, and subsequently implemented or revised several Policies and Procedures to define the scope of responsibility and specific requirements for staff training, including validation of post-training competency; and initiation and implementation of appropriate, individualized client care plans and oversight of same.

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)(B),(1)(D), (1)(P)&(3)(A) and 217.12(1)(A),(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 584603 and Vocational Nurse License Number 131270, heretofore issued to KIM ILINE SOTO, including revocation of Respondent's licenses to practice nursing in the State of Texas.

ORDER

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

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized licenses issued to KIM ILINE SOTO, 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. *Information regarding Board-approved courses in Texas Nursing Jurisprudence may be found at the Board's website Board-approved courses may be found at the following Board website address: <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. 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 shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course

shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor 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>.*

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

courses may be found at the following Board website address:

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address:*

<http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order

of the Board and the stipulations on RESPONDENT'S licenses. 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 licenses. 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 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 licenses to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

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

Signed this 16 day of July, 2010.

Kim Iline Soto

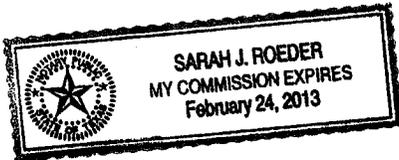
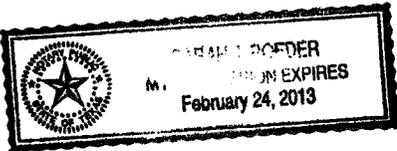
KIM ILINE SOTO, Respondent

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

SEAL

Sarah J. Roeder

Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 16th day of July, 2010, by KIM ILINE SOTO, Registered Nurse License Number 584603 and Vocational Nurse License Number 131270, and said Order is final.

Effective this 17th day of August, 2010.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas". The signature is written in a cursive style and is positioned above a horizontal line.

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