

IN THE MATTER OF
PERMANENT VOCATIONAL NURSE
LICENSE NUMBER 37360
ISSUED TO
DIXIE BRILLHART

§
§
§
§
§
§

BEFORE THE TEXAS
BOARD OF NURSING
ELIGIBILITY AND
DISCIPLINARY COMMITTEE



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.
Patricia R. Plummer
Executive Director of the Board

ORDER OF THE BOARD

TO: DIXIE BRILLHART
308 N. TEXAS #A
DELEON, TX 76444

During open meeting held in Austin, Texas, on November 12, 2013, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

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, Permanent Vocational Nurse License Number 37360, previously issued to DIXIE BRILLHART, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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.

Entered this 12th day of November, 2013.

TEXAS BOARD OF NURSING

BY:



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

Attachment: Formal Charge filed April 12, 2013.

Re: Permanent Vocational Nurse License Number 37360
Issued to DIXIE BRILLHART
DEFAULT ORDER - REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of November, 2013, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested

DIXIE BRILLHART
308 N. TEXAS #A
DELEON, TX 76444

BY:



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

**In the Matter of
Permanent Vocational Nurse
License Number 37360
Issued to DIXIE BRILLHART,
Respondent**

§ **BEFORE THE TEXAS**
§
§
§
§
§ **BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, DIXIE BRILLHART, is a Vocational Nurse holding License Number 37360, which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about July 29, 2011, Respondent failed to comply with the Agreed Order issued to her on April 28, 2011, by the Texas Board of Nursing. Non-compliance is the result of Respondent's failure to comply with Stipulation Number Six (6) of the Agreed Order which states, in pertinent part:

(6) RESPONDENT SHALL, within sixty (60) days of entry of this Order, successfully complete a course in Basic Cardiopulmonary Life Support for Healthcare Providers....

A copy of the April 28, 2011, Agreed Order, Findings of Fact and Conclusions of Law, is attached and incorporated, by reference, as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE II.

On or about April 29, 2012, Respondent failed to comply with the Agreed Order issued to her on April 28, 2011, by the Texas Board of Nursing. Non-compliance is the result of Respondent's failure to comply with Stipulation Number Two (2) of the Agreed Order which states, in pertinent part:

(2) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE III.

On or about April 29, 2012, Respondent failed to comply with the Agreed Order issued to her on April 28, 2011, by the Texas Board of Nursing. Non-compliance is the result of Respondent's failure to comply with Stipulation Number Three (3) of the Agreed Order which states, in pertinent part:

(3) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete a course in physical assessment....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE IV.

On or about April 29, 2012, Respondent failed to comply with the Agreed Order issued to her on April 28, 2011, by the Texas Board of Nursing. Non-compliance is the result of Respondent's failure to comply with Stipulation Number Four (4) of the Agreed Order which states, in pertinent part:

(4) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete a course in nursing documentation....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

CHARGE V.

On or about April 29, 2012, Respondent failed to comply with the Agreed Order issued to her on April 28, 2011, by the Texas Board of Nursing. Non-compliance is the result of Respondent's failure to comply with Stipulation Number Five (5) of the Agreed Order which states, in pertinent part:

(5) RESPONDENT SHALL, within one year (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills"....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) &(10), Texas Occupation Code, and is a violation of 22 TEX. ADMIN. CODE §217.12 (11)(B).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33 and TEX. OCC. CODE Ch. 53. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid

by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars (\$1200.00).

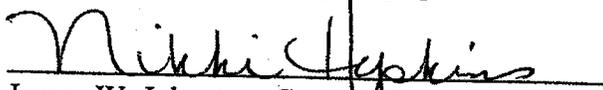
NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order dated April 28, 2011.

Filed this 12th day of April, 2013.

TEXAS BOARD OF NURSING



James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300

Jena Abel, Assistant General Counsel
State Bar No. 24036103

Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924

John R. Griffith, Assistant General Counsel
State Bar No. 24079751

Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847

Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269

John F. Legris, Assistant General Counsel
State Bar No. 00785533

TEXAS BOARD OF NURSING

333 Guadalupe, Tower III, Suite 460

Austin, Texas 78701

P: (512) 305-6811

F: (512) 305-8101 or (512)305-7401

Attachments: Order of the Board dated April 28, 2011

D/2012.06.19

Respondent's nursing employment history continued:

1969 - 1970	Staff Nurse	Johnson County Hospital Cleburne, Texas
1970 - 1974	Charge Nurse	Colonial Manor Cleburne, Texas
1974	Charge Nurse	Burleson Nursing Center Burleson, Texas
1974 - 1976	Charge Nurse	Colonial Manor Cleburne, Texas
1976 - 1978	Charge Nurse	Meridian Nursing Home Meridian, Texas
1978 - 1982	Charge Nurse	Colonial Manor Cleburne, Texas
1982 - 1986	Charge Nurse	Gorman Nursing Home Gorman, Texas
1986 - 1989	Charge Nurse	Canterberry Villa of De Leon De Leon, Texas
1989 - 1996	Charge Nurse	De Leon Nursing Home De Leon, Texas
1997	Staff Nurse	Eastland Health Care Center Eastland, Texas
1997	Charge Nurse	Gorman Nursing Home Gorman, Texas
07/1997 - 08/2002	Charge Nurse	De Leon Nursing Home De Leon, Texas
09/2002 - 01/2003	Charge Nurse	Forrest Oaks Nursing Home Hamilton, Texas
02/2003 - 03/2003	Unknown	
04/2003 - 06/2003	Charge Nurse	Songbird Manor Brownwood, Texas
06/2003 - 07/2003	Charge Nurse	Western Manor/Ranger Care Center Ranger, Texas

Respondent's nursing employment history continued:

08/2003 - 09/2003	Staff Nurse	Granbury Care Center Granbury, Texas
09/2003 - 07/2004	Charge Nurse	Northview Development Center Eastland, Texas
08/2004 - 11/2004	Unknown	
12/2004 - 02/2005	Charge Nurse	Eastland Health Care Center Eastland, Texas
03/2005 - 07/2005	Home Health Nurse	Choice Home Health Care Abilene, Texas
07/2005 - 08/2005	Charge Nurse	Forrest Ridge Care Center Hamilton, Texas
03/2006	Home Health Nurse	The House Kerry Built Abilene, Texas
04/2003 - 05/2003	Unknown	
06/2007 - 04/2008	Charge Nurse	Ranger Care Center Ranger, Texas
10/2007 - 06/2009	Charge Nurse	Homestead Nursing and Rehabilitation Gorman, Texas
06/2009 - Unknown	Charge Nurse	Ranger Care Center Ranger, Texas

6. At the time of the initial incident, Respondent was employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, and had been in this position for three (3) months.
7. On or about January 8, 2008, through January 14, 2008, while employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent failed to document assessments or any interventions in the medical records of four (4) residents assigned to her care, as required. Respondent's conduct resulted in inaccurate, incomplete medical records, and was likely to injure residents in that subsequent care givers did not have accurate and complete information on which to base their decisions.

8. On or about January 27, 2008, through January 28, 2008, while employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent failed to document or completely document any assessments or interventions in the medical records of two residents assigned to her care, as required. Respondent's conduct resulted in inaccurate, incomplete medical records, and was likely to injure residents in that subsequent care givers did not have accurate and complete information on which to base their decisions.
9. On or about January 1, 2009, through January 2, 2009, while employed as a Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent failed to adequately assess and evaluate Resident RA, or notify the physician that the resident was vomiting throughout the shift and had no medications ordered to treat her nausea and vomiting. Respondent's conduct resulted in the delay of medical intervention and was likely to harm the patient from the undetected progression of clinical complications of emesis, including dehydration and aspiration.
10. On or January 2, 2009, while employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent failed to institute the appropriate nursing interventions when she was notified that the abovementioned Resident RA was found lying on her back and unresponsive at approximately 0430 hours. Respondent assessed the patient to be without pulse or respirations, and with cyanotic extremities; however, *she* failed to initiate cardiopulmonary resuscitation (CPR) and call emergency medical services. Although the nurse aides reminded Respondent of the resident's full code status and offered to start CPR, Respondent refused their assistance, and at 0530 hours, attempted to call the hospital, and when unsuccessful, notified the facility Director of Nursing (DON). The resident was later pronounced deceased by the Director of Nursing. Respondent's conduct deprived the resident of resuscitation, which may have contributed to the resident's demise.
11. On or about January 1, 2009, through June 18, 2009, while employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent violated patient confidentiality and failed to maintain the integrity of patient medical records when she removed medical records from the facility to type her nurse's notes at home and did not promptly and correctly place the typed notes in the residents' medical records. Upon her discharge from the facility, numerous resident medical records were found in a container she had been carrying out of the facility. Respondent's conduct was contrary to laws intended to ensure confidentiality of medical records, and may constitute a violation of The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45, Code of Federal Regulations, Parts 160 and 164, *et seq.*
12. On or about January 1, 2009, through June 18, 2009, while employed as a Night Shift Charge Nurse with Homestead Nursing and Rehabilitation of Gorman, Gorman, Texas, Respondent made inaccurate and erroneous entries in the medical records of three residents when she documented that the residents "had expired." Respondent's conduct resulted in inaccurate medical records.

13. In response to the incidents in Findings of Fact Numbers Seven (7) through Twelve (12), Respondent states that she does not recall ever having it brought to her attention that she failed to document in the medical records of patients in January 2008. Regarding Resident RA, Respondent states that she did not feel that there was a change in the resident's condition that warranted notifying the physician because she thought that the vomiting was caused by food the resident ate for supper and the antibiotic the resident had started taking; additionally, she thought the resident was feeling better. Respondent contends that if she encountered this situation again she would notify the on-call physician immediately when the resident vomited the first time. Regarding finding Resident RA unresponsive, Respondent explains that knowing the Resident "was gone," she attempted to call the hospital to contact the on-call physician, and when the Emergency Room nurse called her back at 0445 hours, he told Respondent that the physician said to give post-mortem care. Respondent states that if faced with this situation today, she would get the crash cart and the resident's chart, begin CPR, would order an aide to call 911, and would "keep CPR going" until relieved by paramedics or other appropriate staff. Respondent denies that she violated patient confidentiality and asserts that per instructions of her the DON, she used a USB memory stick provided by the DON that contained the templates of the blank forms on which she typed her notes. According to Respondent, after she typed her notes, she saved them on the USB memory stick, which she then removed from her computer and left at the facility. Respondent states that she did not remove the USB memory stick from the facility and did not do anything that was not authorized by her supervisor. Respondent admits that she erroneously documented in one resident's medical that the resident had expired and explains that she was interrupted while documenting in the correct resident's medical record and accidentally documented in another resident's medical record when she resumed her documentation. Respondent states that when the error was brought to her attention she asked if she could correct the error but she was not allowed to do so. Respondent concludes that because of family illness she had not been getting the rest she needed before going to work.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10) & (13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B),(1)(D),(1)(E)(1)(M),(1)(P)&(2)(A) and 22 TEX. ADMIN. CODE 217.12(1)(A),(1)(B),(1)(C) & (4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against License Number 37360, heretofore issued to DIXIE BRILLHART, including revocation of Respondent's license(s) 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 Vocational Nurse License Number 37360, previously issued to DIXIE BRILLHART, to practice vocational 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, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are 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.

(1) 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.

(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://learningext.com/hives/a0f6f3e8a0/summary>.*

(6) RESPONDENT SHALL, within sixty (60) days of entry of this Order, 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 four and one half (4 ½) hours in length. The course's content shall include: Adult, Infant, and Child 1- and 2- Rescuer CPR; Adult, Infant, and Child Foreign Body Airway 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, <http://www.bon.state.tx.us/disciplinaryaction/pdfs/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 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) YEAR(S) 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 VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS PROBATIONARY PERIOD:

(7) RESPONDENT SHALL notify each present employer in 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 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.

(8) 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.

(9) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse or a Licensed Vocational Nurse. Direct supervision requires another professional or vocational 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.

(10) For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse or a Licensed Vocational 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.

(11) RESPONDENT SHALL NOT practice as a nurse on the night shift, rotate shifts, work overtime, accept on-call assignments, or be used for coverage on any unit other than the identified, predetermined unit(s) to which Respondent is regularly assigned for one (1) year of employment as a nurse.

(12) 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 or Licensed Vocational 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.

IT IS FURTHER AGREED and ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

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

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE

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(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 24th day of March, 2011.

Dixie Brillhart
DIXIE BRILLHART, Respondent

Sworn to and subscribed before me this 24th day of March, 2011.

SEAL



[Signature]
Notary Public in and for the State of Texas

Approved as to form and substance.

[Signature]
Laurie Lindsey, Attorney for Respondent

Signed this 24th day of March, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 24th day of March, 2011, by DIXIE BRILLHART, Vocational License Number 37360, and said Order is final.

Effective this 28th day of April, 2011.


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