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Patricia A. Plummer
Executive Director of the Board

DOCKET NUMBER 507-13-5024

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 510065
ISSUED TO
JAN E. BROWN

§ BEFORE THE STATE OFFICE
§ OF
§ ADMINISTRATIVE HEARINGS
§

OPINION AND ORDER OF THE BOARD

TO: JAN E. BROWN
C/O MARC MEYER, ATTORNEY
33300 EGYPT LANE, SUITE B-200
MAGNOLIA, TX 77354

KERRIE JO QUALTROUGH
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 16-17, 2014, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's exceptions to the PFD; (3) Respondent's response to Staff's exceptions to the PFD; (4) the ALJ's final letter ruling; (5) Staff's recommendation that the Board adopt the PFD regarding the registered nursing license of Jan E. Brown with changes; and (6) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. Board Staff filed exceptions to the PFD on December 5, 2013. Respondent filed a response to Staff's exceptions to the PFD on December 20, 2013. On January 13, 2014, the ALJ issued her final letter ruling, in which she added additional Finding of Fact Number 40a, but declined to make any other changes to the PFD, including her recommended sanction.

The Board, after review and due consideration of the PFD; Staff's exceptions to the PFD; Respondent's response to Staff's exceptions to the PFD; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein, without modification, including Finding of Fact Number 40a, added by the ALJ in her final letter ruling of January 13, 2014. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Modification

The Board has authority to review and modify a PFD in accordance with the Government Code §2001.058(e). Specifically, §2001.058(e)(1) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ or vacate or modify an order issued by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or conclusions of law¹, the Board agrees with the ALJ's recommendation that the appropriate sanction in this matter is a Reprimand with Stipulations, to include remedial education courses². In addition to the remedial education courses recommended by the ALJ, the Board finds that additional stipulations should be imposed for a two year monitoring period³.

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 3 through 22 and 42 through 47 and Conclusions of Law Numbers 4 through 9 raises concerns about the Respondent's ability to practice nursing safely. The Respondent's pattern of conduct, when considered as a whole, is concerning. Timely and accurate documentation regarding patient assessment and medication administration, as well as attention to detail, are minimum nursing skills that are necessary to ensure the delivery of safe nursing care. For example, although the ALJ found that other nurses would have recognized that the Respondent's patient was a level II fall risk and would not have been misled by the Respondent's indication that the patient was a level I fall risk⁴, the Board finds this to be significant. The Respondent acknowledged that her own assessment of

¹ The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation. As such, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The choice of penalty is vested in the agency, not in the courts. An agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. See *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App. - Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App. - Austin 2005, pet. denied); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

² The Board agrees with the ALJ that the Respondent's conduct collectively warrants a first tier, sanction level II sanction. See pages 25-26 of the PFD.

³ See 22 Tex. Admin. Code §213.33(e)(4), which states that "[T]he issuance of a Reprimand shall include reasonable probationary stipulations which may include practice for a specified period of at least two years under the directions of a registered nurse or vocational nurse designated by the Board."

⁴ See adopted Findings of Fact Numbers 5-10 and pages 4-6 of the PFD.

the patient led her to believe the patient was a level I fall risk⁵, even though the patient had several level II risk factors⁶ that should have been readily apparent⁷. Of further concern is the fact that Respondent has been issued three prior Board orders, the most recent in 2010⁸. The Respondent's history of repeated violations of the Nursing Practice Act and Board rules does not instill any confidence that the Respondent has learned from her past mistakes or is able to avoid such errors in the future. Further, the Board remains cognizant that it must consider taking a more severe disciplinary action if an individual has previously been disciplined by the Board or is being disciplined for multiple violations of the Nursing Practice Act (Occupations Code Chapter 301) than would be taken if the individual had not been previously disciplined by the Board or is being disciplined for a single violation⁹.

Further, the Board notes that the ALJ found little mitigating evidence during hearing. The Respondent presented evidence from a fellow nurse stating that Respondent is a team player, a good educator for co-workers, and a strong advocate for her patients¹⁰ and no actual harm resulted from the Respondent's conduct¹¹.

The Board has considered the aggravating and mitigating factors in this matter. Pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e), (f), and (g), the Board finds that a Reprimand with Stipulations for two years is the most appropriate sanction in this matter. The Board finds that remedial education courses and a fine of \$750 should be imposed against the Respondent's license¹². The Board disagrees with the ALJ that direct supervision is not warranted in this case. The Respondent's conduct evidences a troubling pattern of conduct. Despite the fact that the Respondent has been previously disciplined by the Board, she continues to engage in conduct that violates the Nursing Practice Act and Board rules. Further, although no actual patient harm occurred in this case, the Respondent's conduct poses a risk of harm to patients if not successfully remediated. Based upon the Respondent's extensive disciplinary history with the Board and the Respondent's continued violations of the Nursing Practice Act and Board rules, the Board finds that employer notifications, supervised practice for the first year of the Order, indirect supervision for the second year of the Order, and quarterly employer reports are warranted for the two year monitoring period. These stipulations will enable the Board to remain

⁵ See page 5 of the PFD.

⁶ See adopted Finding of Fact Number 5.

⁷ Particularly if other nurses would have recognized the risk and would not have been misled by Respondent's erroneous indication. See adopted Findings of Fact Numbers 8-10.

⁸ See adopted Findings of Fact Numbers 45-47.

⁹ Occupations Code §301.4531 and 22 Tex. Admin. Code §213.33(b).

¹⁰ See page 24 of the PFD.

¹¹ See adopted Findings of Fact Numbers 11 and 41.

¹² See 22 Tex. Admin. Code §213.33(f) and §213.32(6). Section 213.32(6) permits issuance of a fine in conjunction with other sanctions authorized by Board rules. Respondent's conduct resulted in multiple violations of Board rules. These violations support imposition of a \$250 fine for the first occurrence and an additional \$500 for a second violation.

informed about the Respondent's practice while under the terms of this Order and ensure that the Respondent's practice is being supervised in accordance with the terms of this Order. The Board also finds that the Respondent should be restricted from practicing in certain independent, autonomous, or unsupervised settings. These restrictions are necessary to ensure that the appropriate type of supervision is provided for the Respondent. Supervision that would be required under this Order is not typically provided for in autonomous settings, such as home health settings. Further, these restrictions are necessary to ensure a consistency in the Respondent's supervision so that patterns of practice may be effectively monitored and, if problematic, identified quickly. It is difficult to consistently observe a nurse's practice if the nurse works for several different employers or works for an agency, which may place the nurse at different facilities on a short term basis. Further, these conditions are authorized under 22 Tex. Admin. Code §213.33(e)(4) and are consistent with Board precedent and prior administrative decisions involving similar violations.

IT IS THEREFORE ORDERED, that Respondent, JAN E. BROWN, SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS AND A FINE and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 et seq., the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 Tex. Admin. Code §211.1 et seq. and this Order.

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

IT IS FURTHER ORDERED that while Respondent's license(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.

IT IS FURTHER ORDERED 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.texas.gov/compliance>.

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

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. Board-approved courses may be found at the following Board website address: <http://www.bon.texas.gov/compliance>.

(4) RESPONDENT SHALL pay a monetary fine in the amount of seven hundred and fifty dollars (\$750). RESPONDENT SHALL pay this fine within forty five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IT IS FURTHER ORDERED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

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

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

(7) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as 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.

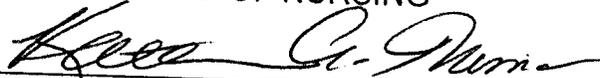
(9) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) year(s) of employment as a nurse.

IT IS FURTHER ORDERED, 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 may be eligible for nurse licensure

compact privileges, if any.

Entered this 16th day of April, 2014.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision and ALJ Final Letter Ruling, dated January 13, 2014;
Docket No. 507-13-5024 (November 20, 2013).

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

November 20, 2013

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

VIA INTERAGENCY

RE: **Docket No. 507-13-5024; *In the Matter of Jan E. Brown***

Dear Ms. Thomas:

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

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Kerrie Jo Qualtrough
Administrative Law Judge

KJQ/vg
Enclosures

XC: John R. Griffith, Assistant General Counsel, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701
- VIA INTERAGENCY
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - VIA INTERAGENCY
Marc M. Meyer, Law Office of Marc Meyer, PLLC, Texas Nursing & EMS Lawyer, 33300 Egypt Lane, Ste. B200, Magnolia, TX 77354-2878 - VIA REGULAR MAIL

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Account Number: 161
Upload Description: Proposal for Decision

SOAH DOCKET NO. 507-13-5024

TEXAS BOARD OF NURSING,
Petitioner

v.

JAN E. BROWN, PERMANENT
REGISTERED NURSE
LICENSE NO. 510065,
Respondent

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-13-5024

TEXAS BOARD OF NURSING,
Petitioner

v.

JAN E. BROWN, PERMANENT
REGISTERED NURSE
LICENSE NO. 510065,
Respondent

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BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Board) seeks to take disciplinary action against the registered nurse license of Jan E. Brown (Respondent) for five violations. After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds that Respondent committed three of the five alleged violations and recommends that the Board issue a Reprimand with Stipulations.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Matters concerning notice and jurisdiction were undisputed. Therefore, those matters are set out in the findings of fact and conclusions of law without further discussion here.

ALJ Kerrie Jo Qualtrough convened the hearing on the merits on October 1, 2013, at the State Office of Administrative Hearings in Austin, Texas. Assistant General Counsel John R. Griffith represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on October 1, 2013.

II. APPLICABLE LAW

Chapter 301 of the Texas Occupations Code and the Board's rules¹ govern the practice of nursing in Texas. Under chapter 301, a person is subject to disciplinary action for unprofessional

¹ 22 Tex. Admin. Code part 11.

or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public;² and for the failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm.³

Under the Board's rules, "unprofessional conduct" includes:

- carelessly or repeatedly failing to conform to generally accepted nursing standards in an applicable practice setting;⁴
- improperly managing patient records;⁵
- carelessly or repetitively endangering a patient's life, health, or safety, for which actual injury to a patient need not be established;⁶ and
- falsifying reports and patient documentation.⁷

The Board has also adopted standards that establish minimum levels of acceptable nursing practice. The standards require that all nurses must:

- implement measures to promote a safe environment for patients and others;⁸
- know the rationale for and the effects of medications and correctly administer the medications;⁹
- accurately and completely report and document the patient's status including signs and symptoms; nursing care rendered; physician orders; administration of

² Tex. Occ. Code § 301.452(b)(10).

³ Tex. Occ. Code § 301.452(b)(13).

⁴ 22 Tex. Admin. Code § 217.12(1)(B).

⁵ 22 Tex. Admin. Code § 217.12(1)(C).

⁶ 22 Tex. Admin. Code § 217.12(4).

⁷ 22 Tex. Admin. Code § 217.12(6)(A).

⁸ 22 Tex. Admin. Code § 217.11(1)(B).

⁹ 22 Tex. Admin. Code § 217.11(1)(C).

medications and treatments; patient responses; and contacts with other health care team members concerning significant events regarding patient's status;¹⁰ and

- collaborate with the patient and members of the health care team.¹¹

III. DISCUSSION

Respondent has been practicing nursing for 30 years and was first licensed to practice in Texas in August 1983.¹² From May 2011 through August 2011, the time period relevant to this hearing, Respondent was employed by the Cedar Park Regional Medical Center.

In five separate charges, Staff alleged that Respondent's conduct violated the standards of nursing practice and constituted unprofessional conduct. It is Staff's position that these are serious violations and, given Respondent's three prior Board orders, demonstrate a long history of misconduct. Staff recommends an enforced suspension of Respondent's license contingent on the completion of certain educational requirements, and then a 3-year probationary period with both direct and indirect supervision.

Respondent believes that the five charges brought against Respondent are relatively minor mistakes that every nurse makes. Respondent further asserts that she was never remediated by her employer for these mistakes and a peer review was never done. It is Respondent's position that these minor incidents do not warrant Staff's recommended penalty.

¹⁰ 22 Tex. Admin. Code § 217.11(1)(D).

¹¹ 22 Tex. Admin. Code § 217.11(1)(P).

¹² Staff Ex. 11 at 1; Staff Ex. 12 at 2.

A. Charge I**1. Staff's Allegation and Evidence**

Staff alleged in its Formal Charges that on or about May 4, 2011, Respondent incorrectly documented on the Daily Assessment/Observation Record (Daily Assessment) that Patient No. 765728 was a Fall Risk Level I patient, when the patient was actually a Fall Risk Level II. According to Staff, Respondent's conduct created an inaccurate medical record that "was likely to injure the patient in that subsequent care givers would not have accurate information on which to base their care decisions."¹³ Staff asserts that this conduct violated the nursing practice standards in 22 Texas Administrative Code § 217.11(1)(B) and (D) and constituted unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(B) and (4).

Bonnie Cone, a "Nursing Consultant for Practice," testified on behalf of Staff. According to Ms. Cone, the Daily Assessment sets out the factors related to a patient's risk of falling,¹⁴ and it is apparent from the record that the patient had several Level II risk factors. The patient was over the age of 65¹⁵ and was on pain medication.¹⁶ In addition, the patient was an amputee¹⁷ and used a wheelchair at home for mobility.¹⁸ Also, the patient suffered from a decubitus ulcer, as shown on the skin integrity section of the Daily Assessment.¹⁹ Ms. Cone testified that these are Level II risk factors and Respondent should have indicated that the patient was a Level II Fall Risk by checking the correct box on the Daily Assessment form.

Ms. Cone stated that inaccurate records create a risk of harm for the patient. Failing to accurately document a patient's condition deprives nurses on subsequent shifts the information

¹³ Staff Ex. 3 at 3.

¹⁴ Staff Ex. 13 at 165.

¹⁵ Staff Ex. 13 at 165.

¹⁶ Staff Ex. 13 at 168.

¹⁷ Staff Ex. 13 at 150.

¹⁸ Staff Ex. 13 at 168.

¹⁹ Staff Ex. 13 at 165.

they need to assess the condition of the patient because a nurse cannot look back in the record to see if or how the patient's condition has changed.

2. Respondent's Evidence

Respondent testified that she always does her own assessments, and at the time she filled out the Daily Assessment for this particular patient, she thought the patient was a Level I Fall Risk. Further, regardless of Respondent's assessment, hospital staff put a yellow star on the door of those patients who are a Level II Fall Risk. This yellow star notifies all hospital staff of the patient's condition. Therefore, if Respondent made an error on the patient's Daily Assessment, other nurses would still see the yellow star on the patient's door and take the necessary precautions.

3. ALJ's Analysis

The Staff met its burden of proof that by checking the wrong box on the Daily Assessment form, Respondent failed to accurately and completely report and document the client's status, as required by 22 Texas Administrative Code § 217.11(1)(D). The evidence shows that this patient was a Level II Fall Risk because the patient was over 65 years of age, was on pain medication, had a decubitus ulcer, and was an amputee.²⁰ However, it appears to the ALJ that Respondent simply made a mistake by checking a box that indicated the patient was a Level I Fall Risk. The patient suffered no harm from that mistake, and any risk due to the mistake was minimal.

Also, the ALJ concludes that continuity of care for this patient was not interrupted because subsequent nurses could not be misled by Respondent's mistake. The fall risk factors of age and amputation are factors that do not change from shift to shift. As Ms. Cone testified, each nurse at the beginning of each shift has the responsibility to make an independent assessment of the patient. Therefore, it would be apparent to any nurse looking at Respondent's Daily

²⁰ Staff Ex. 13 at 150.

Assessment form that Respondent made a mistake by checking the wrong box on the form. It is unlikely that subsequent nurses would rely on the box indicating a Level I Fall Risk and deny this patient the appropriate level of nursing care.

The ALJ further concludes that Staff did not meet its burden of proof that Respondent failed to meet the standard found in section 217.11(1)(B) of the Board's rules because it is unlikely that a mistakenly-checked box would promote an unsafe environment for this particular patient. The ALJ also finds that Respondent did not commit the unsafe practices enunciated in section 217.12(4) of the Board's rules because the evidence is insufficient to show that Respondent exhibited "careless or repetitive conduct that may endanger a patient's life, health, or safety," as required for a finding of unprofessional conduct under this section. Nor does Respondent's error rise to the level of an unsafe practice under section 217.2(1)(B). The evidence is insufficient to show that Respondent "[c]arelessly or repeatedly fail[ed] to conform to generally accepted nursing standards in applicable practice settings."

B. Charge II

I. Staff's Allegation and Evidence

Staff alleges that on or about May 5, 2011, Respondent falsely documented the administration of Tramadol to Patient 765567 at 0400 hours, thereby creating an inaccurate medical record that could have resulted in the patient receiving a non-efficacious treatment.²¹ According to Staff, this conduct violated the Board's rules on the standards of nursing practice found in 22 Texas Administrative Code § 217.11(1)(B) and (1)(D) and constituted unprofessional conduct under section 217.12(1)(B), (1)(C), (4), and (6)(A).

Ms. Cone testified that the physician prescribed Tramadol, given every 8 hours, for this patient, as specified in the Medication Administration Record (MAR).²² The MAR is a calendar

²¹ Staff Ex. 3 at 3.

²² Staff Ex. 13 at 447.

for medication that is used by nurses to document when medication is administered to a patient so that nurses on subsequent shifts can determine the time of the next dose.

In this case, Respondent indicated on the MAR that she gave the patient the prescribed dose of Tramadol at 2000 hours on May 4, 2011, and again at 0400 hours on May 5. However, Staff argues that Respondent did not give the medication on May 5 as she indicated on the MAR. According to Ms. Cone, the "Accudose-RX Station Events Report (By User)" (Accudose Report) shows that the only time Respondent obtained Tramadol for this patient was on May 4 at 1945 hours.²³ The Accudose Report is a record that shows the date and time the Accudose system dispensed medication to a nurse for each of her patients. In this case, the Accudose Report does not show that Respondent obtained Tramadol for the patient on May 5 at a time corresponding to 0400 hours, as Respondent had indicated on the MAR.

Ms. Cone testified that an accurate MAR is necessary for the proper care of a patient. If a nurse indicated on the MAR that she gave a prescribed medication at a certain time, a subsequent nurse would believe that the patient got the medication as shown on the MAR. However, if a patient did not receive the scheduled medication, then the patient would be deprived of her scheduled dose of medication. In this case, the physician issued an order, prescribing Tramadol every 8 hours.²⁴ According to Ms. Cone, if the patient did not get Tramadol at 0400 hours as Respondent indicated on the MAR, then the patient would have gone 16 hours without the prescribed pain medication.

2. Respondent's Evidence

Respondent testified that she had no independent recollection of the care for this patient. However, she stated that if she had signed for the Tramadol on a patient's chart, she would have given the medication to the patient. She also testified that sometimes a charge nurse would give medication to a patient instead of the assigned nurse, and if a nurse "pulls" the medication, then

²³ Staff Ex. 7 at 60.

²⁴ Staff Ex. 13 at 447.

the nurse "gives" the medication and "signs" for the medication. She stated that if she knew a medication had been given by a charge nurse but was not indicated on a patient's chart, then she would sign for it if she knew that the charge nurse had in fact given the medication.

In her response to Staff's request for disclosures, Respondent stated that the patient was asleep when she attempted to administer the Tramadol at 0400 hours on May 5.²⁵ At the hearing, Respondent testified that, if the patient had been asleep, she would have circled the 0400 notation on the MAR. However, because the 0400 notation on the MAR was not circled,²⁶ Respondent testified that she may have just forgotten to circle the notation on the MAR.

Regarding the missing May 5 entry on the Accudose Report, Respondent could not speak to the accuracy of the report because, in her opinion, the Accudose system at the hospital was "awful" and the system made "multiple mistakes every day." On Respondent's floor, there were three Accudose stations: one on the north wing, one on the south wing, and one in the intensive care unit (ICU). It was the responsibility of a pharmacy technician to stock the stations with the medications prescribed for patients on the floor. To access the station, a nurse had to log on at the station and enter the patient's information. At that point, a drawer should have popped open containing the prescribed medication. However, if the drawer was empty, the nurse would have had to go to the station in the other wing and begin the process again. If the second station did not have the prescribed drug, then the nurse would have had to go to the ICU, although only ICU nurses could log on at that station. If the medication was not in the ICU station, then a supervisor would have to be called to obtain the necessary medication.

²⁵ Staff Ex. 15 at 2. According to Respondent, her responses to the Staff's requests for disclosures were based on overly-redacted medical records, making it difficult to review and analyze the records for each patient in order to properly respond. These improperly-redacted records were included in Staff Ex. 6. However, Staff only offered the properly-redacted records in Staff Ex. 13, not the improperly-redacted records in Staff Ex. 6. Therefore, Staff Ex. 6 was not admitted into evidence.

²⁶ Staff Ex. 13 at 447.

3. ALJ's Analysis

In its Formal Charges, Staff alleges that Respondent "falsely documented the administration of Tramadol" to this patient at 0400 on or about May 5, 2011, and that the MAR was an "inaccurate medical record and may have resulted in the patient receiving non-efficacious treatment."²⁷ After reviewing the testimony and the documentary evidence, the ALJ concludes that Staff met its burden of proof on the Charge II allegations relating to an inaccurate medical record, but not on the claim that Respondent falsified the MAR.

The following table is a summary of the evidence regarding the charge of whether Respondent falsely claimed to have given the prescribed Tramadol to the patient on May 5 at 0400 hours.

Document	Event	Date/Time
MAR	Starting date and time for the Tramadol entries	May 4, 2011, at 0700 hours ²⁸
Accudose Report	Tramadol dispensed to Respondent for the patient	May 4, 2011, at 1945 hours ²⁹
MAR	Respondent represented that patient received Tramadol	May 4, 2011, at 2000 hours ³⁰
MAR	Respondent represented that patient received Tramadol	May 5, 2011, at 0400 hours ³¹
Accudose Report	Last entry on report for Respondent	May 5, 2011, at 2245 hours ³²

The Accudose Report and the MAR have corresponding entries for the dispensing of Tramadol to Respondent for the patient on May 4 at 2000 hours. However, the Accudose Report does not have an entry corresponding to the MAR entry of May 5 at 0400 hours.

²⁷ Staff Ex. 3 at 3.

²⁸ Staff Ex. 13 at 447 (top of page indicates date of record).

²⁹ Staff Ex. 7 at 60.

³⁰ Staff Ex. 13 at 447 (sixth column from the left).

³¹ Staff Ex. 13 at 447 (seventh column from the left).

³² Staff Ex. 7 at 60.

The ALJ did not find a definition of the term "falsifying reports," as used in 22 Texas Administrative Code § 217.12(6)(A), in either the Board's rules or chapter 301 of the Texas Occupations Code. Therefore, the ALJ relies on the usual meaning of the term "falsification." Black's Law Dictionary defines "falsifying a record" as "making false entries or otherwise tampering with a public record with the intent to deceive or injure, or to conceal wrongdoing."³³ Other than the absence of an entry on the Accudose Report, there is no evidence in the record on which to base an inference that Respondent acted with the intent to deceive or to falsify a document.

Nevertheless, the evidence is sufficient to conclude that the MAR entry is inaccurate. As shown in her response to Staff's request for disclosure, Respondent stated that she did not give Tramadol to the patient because the patient was asleep. Although she could not remember treating this patient, Respondent speculated that she may have forgotten to circle the notation on the MAR when she attempted to give the patient the Tramadol at 0400 hours and found the patient asleep. The ALJ recognizes that Respondent's disclosures were based upon a review of heavily redacted medical records, making it difficult to properly respond. In addition, the ALJ is cognizant of the fact that the Accudose Report in the record only shows the entries from one of three possible Accudose stations. However, Respondent's employee record shows that there was no corresponding Accudose dispensing record for this patient.³⁴ Therefore, a preponderance of the evidence supports a conclusion that Respondent did not accurately and completely document the administration of medications, a violation under 22 Texas Administrative Code § 217.11(1)(D)(iv).

In addition, there is no evidence to support a finding that Respondent violated a nursing standard by failing to implement measures to promote a safe environment for this patient, as required by section 217.11(1)(B). At most, Staff has shown that Respondent made one erroneous entry on a medical record. It is difficult to extrapolate from one erroneous entry that Respondent somehow promoted an unsafe environment for this patient. Nor can the ALJ

³³ Black's Law Dictionary 619 (7th Ed. 1999).

³⁴ Staff Ex. 5 at 43.

conclude that the evidence demonstrates that Respondent's behavior rises to the level of unprofessional conduct under section 217.12 of the Board's rules. There is no evidence of carelessness or the repeated failure to conform to nursing standards, as is required to show that Respondent's conduct was an unsafe practice as defined by section 217.12(1)(B). Further, in the ALJ's opinion, the evidence of one erroneous entry is insufficient to support a finding that Respondent improperly managed patient records, as required by section 217.12(1)(C), or that she carelessly or repetitively engaged in conduct that endangered the patient's life, health, or safety, as required by section 217.12(4).

C. Charge III

1. Staff's Allegation and Evidence

Staff alleges that on May 5, 2011, Respondent failed to administer the prescribed dose of Norco by mouth every 4 hours to Patient 765346 as ordered by the physician. Instead, Staff asserts that Respondent administered Morphine intravenously to the patient, which the physician had ordered, but only for breakthrough pain. Staff argues that Respondent's conduct violated the standards of nursing practice found in 22 Texas Administrative Code § 217.11(1)(B) and (1)(C) and constituted unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(B) and (4).³⁵

Ms. Cone testified that this patient was admitted to Respondent's unit for post-surgical observation on May 5, 2011. At 1850 hours on that day, the physician entered a "range order" for pain. If the patient experienced pain on a range of one-to-four, then the patient was to receive one Norco tablet as needed. If the pain exceeded a pain level of four, then the patient could receive two Norco tablets as needed. In addition, the patient could receive Morphine intravenously as needed for breakthrough pain.³⁶

³⁵ Staff Ex. 3 at 4.

³⁶ Staff Ex. 13 at 523.

Staff asserts that Respondent did not follow the physician's range order because Respondent did not administer Norco before administering Morphine. The MAR shows that Morphine was given to the patient at 2300 hours on May 5, and again at 0225 hours and 0530 hours on May 6.³⁷ However, neither the MAR nor Respondent's notes on the Daily Assessment indicate that Norco was given to this patient.³⁸ By failing to first give the patient Norco as ordered by the physician, Respondent contravened the physician's range order, according to Ms. Cone.

Ms. Cone stated that a nurse acts outside her scope of practice when she does not follow a physician's orders. Nurses do not have advanced degrees and cannot make treatment decisions for a patient. Also, by failing to give the patient Norco, Respondent deprived the patient of the opportunity to see if Norco would be sufficient to treat his pain.

Ms. Cone testified that a nurse can only "re-think" a physician's order if the nurse knows that the medication would harm the patient, as when a patient is allergic to the prescribed medication. In that case, a nurse must first inform the physician of such a complication and note that on her Daily Assessment.

2. Respondent's Evidence

Respondent testified that this patient was a "fresh post-op patient with anesthesia on board," indicating that the patient was or had been sedated. These patients typically came to her unit with nausea and no bowel sounds. She stated that if there are no bowel sounds, then oral medication would not be absorbed and could make the patient "throw up." According to Respondent's notes, this patient had no bowel sounds on May 5, 2011, at 1930 hours,³⁹ and she testified that the patient did not regain bowel sounds during her shift.

³⁷ Staff Ex. 13 at 589.

³⁸ Staff Ex. 13 at 589, 580.

³⁹ Staff Ex. 13 at 580.

Respondent stated that she made the judgment call to give the Morphine intravenously because of this patient's nausea and lack of bowel sounds. The physician had ordered Morphine as needed, and intravenous Morphine would be more efficient in relieving the pain and would cause no harm to the patient.

In addition, Respondent testified that she did in fact communicate this information to the physician by telephone. As shown in the patient's record, she received a telephone order from the physician at 2220 hours on May 5.⁴⁰ The notes indicate that the physician prescribed Zofran for nausea, and Respondent testified that she would have discussed the patient's pain medication with the physician during that telephone call.

3. ALJ's Analysis

The ALJ has reviewed the documentation and has determined that the records support Respondent's version of the events of May 5, 2011, and the dispensing of Morphine. The following timeline shows the sequence of events regarding this patient.

Date	Time	Entry
May 5, 2011	1850 hours	Physician enters a range order for Norco for pain as needed, and Morphine as needed for breakthrough pain. ⁴¹
	1930 hours	Respondent examines patient and notes the absence of bowel sounds. ⁴²
	2220 hours	Physician checked on the patient by telephone, and Respondent received orders. ⁴³

⁴⁰ Staff Ex. 13 at 524.

⁴¹ Staff Ex. 13 at 523.

⁴² Staff Ex. 13 at 580.

⁴³ Staff Ex. 13 at 580.

Date	Time	Entry
	2220 hours	Respondent notes that physician gave a telephone order for Zofran for nausea. ⁴⁴
	2300 hours	MAR indicates that patient received Morphine. ⁴⁵
	2300 hours	Daily Assessment shows patient was medicated for pain. ⁴⁶
May 6, 2011	0225 hours	MAR indicates that patient received Morphine. ⁴⁷
	0225 hours	Daily Assessment shows patient was medicated because he was complaining of pain. ⁴⁸
	0530 hours	MAR indicates that patient received Morphine. ⁴⁹
	0530 hours	Daily Assessment shows patient received medication for pain. ⁵⁰

Respondent spoke with the physician at 2220 hours, before the Morphine was administered at 2300 hours. This is consistent with Respondent's testimony that she heard no bowel sounds at 1930 hours, she would have discussed this with the physician at 2220 hours at the same time he ordered Zofran, and she gave the patient intravenous Morphine at 2300 hours. Although Staff argued that the patient's nausea was probably caused by the Morphine, both the MAR and the Respondent's notes show that the physician prescribed Zofran for nausea *before* Respondent administered the Morphine.

A full review of the evidence corroborates Respondent's testimony that she informed the physician of the lack of bowel sounds and he authorized her by telephone to administer the Morphine intravenously, as already authorized for breakthrough pain in the range order. The

⁴⁴ Staff Ex. 13 at 524.

⁴⁵ Staff Ex. 13 at 589.

⁴⁶ Staff Ex. 13 at 580.

⁴⁷ Staff Ex. 13 at 589.

⁴⁸ Staff Ex. 13 at 580.

⁴⁹ Staff Ex. 13 at 589.

⁵⁰ Staff Ex. 13 at 580.

ALJ finds that Respondent was authorized to administer the Morphine intravenously, which she did, as indicated on the MAR⁵¹ and on the Daily Assessment.⁵² The ALJ concludes that Staff did not meet its burden of proof on Charge III.

D. Charge IV

1. Staff's Allegation and Evidence

According to Staff, Respondent administered oxygen to Patient 769379 without documenting the patient's oxygen saturation levels before and after the intervention. Staff alleges that this action deprived the physician of essential information that may have been required to stabilize the patient and may have deprived the patient of timely medical intervention. Staff asserts that Respondent's conduct violated the standards of nursing practice found in 22 Texas Administrative Code § 217.11(1)(B), (1)(D), and (1)(P), in addition to 22 Texas Administrative Code § 217.12(1)(B) and (4).⁵³

Ms. Cone testified that this patient was admitted on June 3, 2011, with symptoms of a transient ischemic attack (TIA). The Patient Admission Assessment Record (Admission Record) indicates that the patient had slurred speech and other symptoms.⁵⁴ The neurological assessment on the Admission Record also shows that the patient felt flushed, was unsteady, had slight tingling all over, "felt hazy," and was "off in a fog."⁵⁵

During the patient's hospital stay, the nursing staff monitored her vital signs and recorded them on the Graphic Sheet Intake and Output record. This record shows that the patient

⁵¹ Staff Ex. 13 at 589.

⁵² Staff Ex. 13 at 580.

⁵³ Staff Ex. 3 at 4.

⁵⁴ Staff Ex. 13 at 681.

⁵⁵ Staff Ex. 13 at 683.

maintained an oxygen saturation level of 100% at each 4-hour assessment, except for 97% at 2000 hours on June 3, 2011, and a 99% saturation level at 1200 hours on June 4.⁵⁶

The Daily Assessment for this patient indicates that Respondent noted on June 3 at 2300 hours that the patient's family expressed concerned because the patient was "not alert anymore."⁵⁷ According to the record, Respondent performed a neurological check and documented that the patient's speech was hesitant, but appropriate, and that she "felt weird."

According to Ms. Cone, Respondent addressed these concerns by giving oxygen to the patient, but she did not document on the Daily Assessment the patient's oxygen saturation levels before or after receiving the oxygen. Respondent's notes on the Daily Assessment only show that, after a few minutes on the oxygen, the patient was alert and active, cheerful, and spontaneous.⁵⁸

Ms. Cone opined that Respondent impermissibly initiated intervention by giving the patient oxygen. There is no indication in the patient's record of a low oxygen saturation level and no indication that the physician had ordered oxygen. Further, there is no indication that Respondent administered oxygen in compliance with a hospital protocol that applies to any patient when the oxygen saturation level drops below a predetermined level. Therefore, based on this medical record and the lack of documentation on oxygen saturation levels, Ms. Cone concluded that Respondent did not notify the physician of the patient's condition.

According to Ms. Cone, Respondent created a risk for the patient by failing to document the oxygen saturation level and by failing to notify the physician of essential information. In this case, the physician would not know to order additional tests because Respondent failed to document the information.

⁵⁶ Staff Ex. 13 at 673.

⁵⁷ Staff Ex. 13 at 690.

⁵⁸ Staff Ex. 13 at 690.

2. Respondent's Evidence

Respondent testified that, as she noted on the record, the patient's family became concerned at approximately 2300 hours on June 3. Respondent stated that she assessed the patient and put her on oxygen. Respondent further testified that she would have then notified the hospital's respiratory therapy staff, who would have taken over the responsibility for the administration of oxygen. Respondent testified that when a patient makes a complaint "that is heart-related," it is standard protocol to put a patient on oxygen first and then ask questions later.⁵⁹

Furthermore, according to Respondent, the physician was in fact in the unit at that time, and Respondent stopped her in the hall and told her about the patient's condition.⁶⁰ The physician went into the patient's room and made her own assessment of the patient's condition after Respondent had put the patient on oxygen. When asked whether she documented that the physician was there, Respondent replied that she "does not document for doctors." Respondent also testified that the patient did not suffer a negative outcome and was discharged the next day.

3. ALJ's Analysis

As stated in its Formal Charges, the basis of Staff's complaint is that Respondent "failed to notify the physician of a change in the condition of [the patient] when the patient experienced decreased level of consciousness, tingling in the hands, and hesitant speech."⁶¹ Staff alleged that Respondent administered oxygen without documenting the oxygen saturation level before and after administering oxygen, and thereby denied the physician of essential information. However, the physician was on the floor at the time Respondent administered the oxygen. As Respondent

⁵⁹ This patient had been admitted for symptoms indicative of a TIA, a neurological condition with symptoms similar to those of a stroke. Staff Ex. 13 at 681, 683. The ALJ construes Respondent's statement about a heart-related complaint as a misstatement in her testimony. Respondent's notes at the time indicate that she was addressing the patient's neurological conditions. Staff Ex. 13 at 690 ("Family concerned. States [patient is] 'not alert anymore.' *Neuro [check] done . . .*" (emphasis added)).

⁶⁰ Although Respondent could not recall the physician's name, she recalled that the physician was a woman.

⁶¹ Staff Ex. 3 at 4.

testified, she consulted with the physician, and the physician examined the patient. Therefore, the physician was not deprived of information necessary to the care for the patient.

In addition, although the patient's oxygen saturation levels do not appear in the record, Respondent clearly documented the patient's symptoms at 2300 hours on June 3, 2011. Respondent performed a neurological check and documented that the patient's speech was slow but appropriate and she had a tingling sensation in her hands. After administering the oxygen, Respondent noted that the patient was alert and oriented, as well as active, cheerful, and spontaneous.⁶² Given that Respondent documented the patient's symptoms and response to the oxygen, the ALJ cannot conclude that a physician would have been denied essential information necessary to make a proper assessment of the patient's condition and to determine whether additional tests were warranted.

The ALJ finds that Staff did not meet its burden of proof that Respondent violated 22 Texas Administrative Code § 217.11(1)(B), (1)(D), and (1)(P), in addition to 22 Texas Administrative Code § 217.12(1)(B) and (4). Respondent collaborated with the patient, the family, and the physician. Respondent did not fail to promote a safe environment for the patient, nor did she fail to accurately and completely report and document the patient's status. The evidence is insufficient to show that Respondent was careless or endangered her patient's life, health, or safety. She also did not fail to conform her actions to generally-accepted nursing practices because she sought out the physician on the floor of the unit and personally explained the patient's condition to the physician. For the reasons stated herein, the ALJ concludes that Respondent did not commit the violations as set out in Charge IV of the Staff's Formal Charges.

⁶² Staff Ex. 13 at 690.

E. Charge V**I. Staff's Allegation and Evidence**

Staff asserts that Respondent failed to perform or to document the performance of a complete nursing assessment for Patient 775249. According to Staff, Respondent's conduct resulted in an incomplete medical record and was likely to injure the patient because subsequent caregivers would rely on Respondent's documentation to provide future patient care. Staff asserts that Respondent's conduct violated the standards of nursing practice found in 22 Texas Administrative Code § 217.11(1)(B) and (1)(D), and constituted unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(B) and (4).⁶³

Ms. Cone testified that Respondent failed to document the patient's general nighttime condition on the Daily Assessment for August 11, 2011.⁶⁴ The Daily Assessment contains boxes for a nurse to check to document the patient's condition. The Daily Assessment for this patient does not indicate the results of Respondent's assessment of the patient's cardiovascular system, pain, gastro-genitourinary system, nutrition/feeding, wound, and skin integrity.⁶⁵ Ms. Cone stated that, from this record, she cannot tell whether Respondent actually performed the required assessments.

According to Ms. Cone, a patient is put at risk if a nurse does not ask the questions and document the answers. If a patient has a complaint, then the nurse deprives the patient of necessary medical intervention. Also, subsequent nursing shifts will not have a complete picture of the patient's condition, thereby depriving the patient of continuity of care.

⁶³ Staff Ex. 3 at 4.

⁶⁴ Staff Ex. 13 at 806.

⁶⁵ Staff Ex. 13 at 806.

2. Respondent's Evidence

Respondent testified that it may have been a lack of time that kept her from fully filling out the Daily Assessment form. She could also have been interrupted by "a code on the floor." Respondent testified that she always documents her assessments in her handwritten notes because not all items would be covered by checking the boxes on the Daily Assessment form. She stated that a hospital may have a policy that requires the entry of the same information on several different forms, but she may not have been able to make all the necessary entries. Sometimes, documentation gets set aside in order to address patient-care concerns, according to Respondent.

Respondent also testified regarding her handwritten notes for the nighttime assessment of this patient.⁶⁶ The patient had been admitted for respiratory concerns, and Respondent's handwritten notes focus on that condition. The patient was alert and oriented and was able to get in and out of bed independently. The patient's IV site was free of infection and his lungs were clear to auscultation. Respondent's notes also explained the instructions regarding the patient's breathing exercises and confirmed that the patient understood those instructions.⁶⁷ She testified that her notes reflect the important issues regarding the patient's hospitalization and that she always conducts an assessment for every patient for every shift.

3. ALJ's Analysis

Staff has met its burden of proof that Respondent failed to check the boxes on the Daily Assessment to document the nursing assessment for the patient's cardiovascular system, gastro-

⁶⁶ Staff Ex. 13 at 809. Apparently, the Daily Assessment form has at least two different sections requiring a nurse to enter information about a patient's condition. As shown on Staff Ex. 13 at 809, space is provided on the Daily Assessment for a nurse to make handwritten notes about the patient. On this page, Respondent documented her assessment of the patient's respiratory condition. Staff Ex. 13 at 806 is another page from the Daily Assessment that has multiple boxes to check multiple about a variety of patient conditions. On this page, Respondent did not check the necessary boxes regarding the various conditions. However, Respondent did check boxes indicating her assessment of the patient's neurological condition, pulmonary condition, musculoskeletal system, fall risk level, and IV site assessment.

⁶⁷ Staff Ex. 13 at 809.

genitourinary system, skin integrity, pain, nutrition/feeding status, and wounds. Also, this information is not documented in Respondent's handwritten notes about this patient. Therefore, the patient's records are incomplete, demonstrating that Respondent did not accurately and completely report and document the patient's status in violation of 22 Texas Administrative Code § 217.11(1)(D).

However, Staff did not prove that Respondent failed to implement measures or promote a safe environment for the patient, as required by section 217.11(1)(B) of the Board's rules. The evidence is insufficient to show that the failure to check boxes created or had the potential to create an unsafe environment for this patient.

Also, the evidence does not show that Respondent's conduct rose to the level of an unsafe practice as defined in 22 Texas Administrative Code § 217.12(1)(B) and (4). Respondent failed to check the boxes regarding the patient's general condition and, as she testified, these conditions were unrelated to the health concern for which he was hospitalized. According to Respondent, nurses are required to fill out a myriad of forms, and sometimes patient care may interrupt the nurse's efforts to comply with this requirement. In addition, there are other medical records in evidence that do not have all of the boxes checked.⁶⁸ This tends to support Respondent's contention that this is minor mistake that other nurses make as well. Finally, the ALJ concludes that the failure to check boxes on one page of a form is not sufficient to demonstrate that Respondent was careless or repeatedly failed to conform to generally-accepted nursing standards or endangered the patient's life, health, or safety.

F. Recommended Sanction

The Board has adopted a Disciplinary Matrix to govern the assessment of sanctions for violations of the Texas Occupations Code and the Board's rules and orders.⁶⁹ According to the

⁶⁸ Staff Ex. 13 at 805, 817.

⁶⁹ 22 Tex. Admin. Code § 213.33(b).

Disciplinary Matrix, the Board may impose more severe disciplinary action if the nurse is to be disciplined for multiple violations or had prior Board orders.

Respondent has three prior Board orders. The Board issued its first order in November 2000, and Respondent received the sanction of Reprimand with Stipulations. The order was entered after a contested case hearing and a proposal for decision⁷⁰ regarding a home health care agency owned by Respondent.⁷¹ The Board order required Respondent to complete nursing courses in jurisprudence, documentation, and ethics, and to be indirectly supervised for 1 year.⁷²

The Board issued its second order in November 2006. This was an agreed order addressing Respondent's failure to provide CPR to a patient in 2005.⁷³ As a result of the agreed order, the Board suspended Respondent's license for 2 years, and that suspension was stayed and Respondent placed on probation. Respondent was ordered to complete the nursing courses in jurisprudence, ethics, and basic cardiopulmonary life support for healthcare providers. Respondent was subject to indirect supervision for 2 years.⁷⁴

The third order was issued by the Board in August 2010 as a result of another agreed order. This order found that in 2006, Respondent failed to notify a physician that a patient had fallen on the floor and sustained a scalp hematoma, thereby depriving the physician of essential information. As a result of the violation, Respondent received a Warning with Stipulations, including the standard requirements to take courses in jurisprudence, ethics, and sharpening critical thinking skills. The Board also required indirect supervision for 1 year.⁷⁵

⁷⁰ Staff Ex. 9 (SOAH Docket No. 507-00-1226 (Oct. 6, 2013)).

⁷¹ Respondent testified that she was unaware that the contested case hearing would be a formal hearing with the ability to present evidence. However, the ALJ in this case cannot revisit and reassess the issues in the prior case.

⁷² Staff Ex. 10.

⁷³ Respondent testified in this case that she did not perform CPR on the patient because there was a "do not resuscitate" order for the patient. Again, the ALJ is unable to disregard the November 2006 Board order.

⁷⁴ Staff Ex. 11.

⁷⁵ Staff Ex. 12.

1. Staff's Position

It is Staff's position that although each incident in this case by itself may be minor, the violations demonstrate a repeated pattern of bad nursing practice on behalf of Respondent. She has multiple documentation errors and three prior Board orders for similar violations such as failure to document and failure to notify a physician. In each of those prior orders, the Board required indirect supervision and numerous courses, yet Respondent did not improve her nursing practices and she continues to violate the standards. Patients are put at risk by Respondent's failure to document and follow a physician's orders, according to Staff. In addition to the three prior Board orders, her past employer repeatedly warned Respondent about medication and documentation errors.⁷⁶

Staff contends that the five violations establish a pattern and, given the substantial aggravating factors of three prior Board orders, the appropriate sanction under the Board's Disciplinary Matrix is a Tier 2, Sanction Level 1 sanction. The Staff asserts that the following stipulations should be imposed on Respondent's license:

1. Respondent's license should be subject to a 3-year suspension.
2. The suspension should be enforced until the time Respondent completes a nursing refresher course with a clinical component.
3. Once the nursing refresher course is completed, the Board could reinstate Respondent's license but probated for 3 years.
4. During the first year of probation, Respondent should be subject to direct supervision.
5. During the second and third years of probation, Respondent should be subject to indirect supervision.
6. Respondent should be required to complete the standard courses in jurisprudence, documentation, and critical thinking.

2. Respondent's Position

Respondent argues that the five charges involve minor incidents that did not result in any harm to any patient. According to Respondent, there is no evidence of unsafe practices and

⁷⁶ Staff Ex. 5.

ultimately, the allegations involve documentation issues. A fellow nurse stated that she has found Respondent to be a professional team player, a good educator for co-workers, and a strong advocate for her patients.⁷⁷ Furthermore, the type of minor incidents alleged in this case should have been addressed by Respondent's former employer, and yet no peer review was done pursuant to 22 Texas Administrative Code § 217.16(c)(2)(B).⁷⁸

Respondent asserts that the alleged documentation errors, such as failing to check a box, are committed by nurses in Texas every day. The allegations were addressed by Respondent's former employer, who concluded that five minor errors committed over three months justified the termination of Respondent's employment. Therefore, no additional disciplinary action is required in this proceeding, according to Respondent.

In the alternative, Respondent maintains that any sanction imposed should be "one step up" from Respondent's prior Board orders, which imposed warnings with stipulations.⁷⁹ Therefore, it is Respondent's position that a reprimand with reasonable stipulations related to documentation should be imposed. If a sanction is warranted, it should include only indirect supervision because no harm came to any of Respondent's patients.

3. ALJ's Recommendation

Staff alleged that Respondent committed acts that would subject her to disciplinary action under section 301.452(b)(10) and (b)(13) of the Texas Occupations Code. Section 301.452(b)(10) authorizes disciplinary action for unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient. The ALJ has concluded that Staff did not meet the burden of proof that Respondent committed unprofessional conduct under 22 Texas Administrative Code § 217.12. Therefore, a sanction analysis under the Disciplinary Matrix

⁷⁷ Resp. Ex. A.

⁷⁸ Although it is undisputed that Respondent's conduct was not the subject of a peer review, Respondent did not explain the impact this fact should have on this proceeding or on the sanction. Respondent may explain the legal effect of the lack of a peer review in exceptions.

⁷⁹ In the Board's 2000 order, Respondent received a Reprimand with Stipulations as a sanction, not a warning. Staff Ex. 10 at 2.

regarding section 301.452(b)(10) is not warranted. However, Staff has met its burden of proof regarding Respondent's failure to conform to nursing standards, which is a basis for disciplinary action under Texas Occupations Code § 301.452(b)(13). Therefore, the ALJ will address the violation under the Disciplinary Matrix pertaining to section 301.452(b)(13).

For a nurse's failure to conform to the minimum standards of acceptable nursing practice that exposes a patient unnecessarily to the risk of harm, the Disciplinary Matrix establishes three tiers of offenses: low risk of patient harm (First Tier); risk of patient harm (Second Tier); and serious risk of harm or death (Third Tier). The ALJ concludes that Charges I, II, and IV constitute First Tier offenses because each of these three violations indicates a practice below the standard but with a low risk of patient harm. Respondent's three prior Board orders and the multiple violations proved in this proceeding are aggravating factors that warrant an increased sanction under Sanction Level II.

As shown by Staff, Respondent did not meet the minimum standards of nursing practices relating to documentation, even after Respondent was disciplined for similar conduct. Given this aggravating factor, the ALJ recommends a Reprimand with Stipulations as set out in the Disciplinary Matrix for a First Tier offense under Texas Occupations Code § 301.452(b)(13) with a Sanction Level II, which requires a warning or reprimand.

The Staff recommended that Respondent's license be subject to an enforced suspension until Respondent takes a nursing refresher course. As Ms. Cone testified, this refresher course covers basic knowledge of nursing practices and skills and includes a clinical component. However, none of the proven violations in this case indicate that Respondent's nursing skills have so deteriorated that a refresher course is warranted. At most, Staff has shown that Respondent has failed to complete patients' records fully and accurately. In the ALJ's opinion, these documentation violations do not warrant a refresher course on all aspects of the nursing profession.

In addition, the ALJ recommends that Respondent be indirectly supervised for a period of 3 years. Although Respondent was indirectly supervised as a result of the three prior Board

orders, it is the ALJ's opinion that direct supervision is not warranted in this case, given that the violations concern documentation errors with little or no risk of harm to any patient. The ALJ cannot conclude that direct, "shoulder-to-shoulder" supervision is warranted for these three violations. In addition, two of the prior Board orders did not require direct supervision even though patient harm occurred in those cases.⁸⁰ For the reasons stated herein, the ALJ cannot see the benefit of requiring direct supervision in response to the documentation errors proven in this case.

IV. SUMMARY

The ALJ concludes that Staff has shown that Respondent failed to meet the nursing practice standard found in 22 Texas Administrative Code § 217.11(1)(D), as alleged in Charges I, II, and V. In all other respects, Staff did not prove the allegations in its Formal Charges by a preponderance of the evidence. In support of the conclusions in this proposal for decision, the ALJ makes the following proposed findings of fact and conclusions of law.

V. FINDINGS OF FACT

1. Jan E. Brown (Respondent) is a registered nurse holding license number 510065 issued by the Texas Board of Nursing (Board).
2. Respondent has been practicing nursing for 30 years. Respondent has been licensed to practice in Texas since August 1983.
3. Respondent was employed by the Cedar Park Regional Medical Center during the time period of the alleged violations set out in Staff's Formal Charges.
4. On May 4, 2011, Respondent failed to indicate on the Daily Assessment/Observation Record (Daily Assessment) that Patient 765728 was a Level II Fall Risk. Instead, Respondent checked the box indicating that Patient 765728 was a Level I Fall Risk.

⁸⁰ Staff Ex. 11 (Respondent failed to initiate CPR on a patient; Board imposed indirect supervision for two years); Staff Ex. 12 (Respondent failed to notify physician after she found patient had fallen and was injured; Board imposed indirect supervision for one year).

5. Patient 765728 had several Level II risk factors. The patient was over the age of 65, was an amputee, and was on pain medication. The patient used a wheelchair at home and had a decubitus ulcer.
6. Respondent should have indicated that Patient 765728 was a Level II Fall Risk.
7. Each nurse is required to assess a patient's condition at the beginning of the nurse's shift.
8. The patient's age and status as an amputee are fall risk factors that qualified Patient 765728 as a Level II Fall Risk, but these factors do not change from shift to shift.
9. Nurses on subsequent shifts would not have been misled by Respondent indicating that Patient 765728 was a Level I Fall Risk.
10. Other nurses would have recognized that Patient 765728 was a Level II Fall Risk. Also, a yellow star was placed on Patient 765728's room, indicating to all hospital staff that the patient was a Level II Fall Risk. Any risk to Patient 765728 because of Respondent's error was minimal.
11. Patient 765728 was not harmed by Respondent checking the wrong box indicating that Patient 765728 was Level I Fall Risk.
12. On May 5, 2011, at 1850 hours, the physician for Patient 765567 ordered that the patient should receive Tramadol every 8 hours for pain.
13. The Medication Administration Record (MAR) and the "Accudose-RX Station Events Report (By User)" (Accudose Report) for Patient 765567 reflect the entries for the dispensing of Tramadol to this patient on May 4 through May 5, 2011.
14. The Accudose system dispensed Tramadol to Respondent for Patient 765567 on May 4, 2011, at 1945 hours.
15. Respondent represented on the MAR that Patient 765567 received Tramadol on May 4, 2011, at 2000 hours.
16. Respondent gave Tramadol to Patient 765567 on May 4, 2011, at 2000 hours.
17. Respondent represented on the MAR that Patient 765567 received Tramadol May 5, 2011, at 0400 hours.
18. The Accudose Report does not show that the Accudose system dispensed Tramadol to Respondent at a date and time corresponding to the entry on the MAR showing that Respondent administered Tramadol to Patient 765567 on May 5, 2011, at 0400 hours.
19. The Accudose Report shows the medications that were dispensed to Respondent from a single station. There are three stations on the floor of the hospital where Respondent could have obtained Tramadol for the patient. The Accudose Report does not reflect the medications dispensed from two of the three stations.

20. As part of an audit conducted by her employer, Cedar Park Regional Medical Center, it was determined that Respondent had signed off on the MAR but there was no documentation that the medication was pulled from the Accudose dispensing system for Patient 765567.
21. Patient 765567 did not receive the medication on May 5, 2011, at 0400 hours.
22. The entry on the MAR showing that Tramadol was dispensed to Patient 765567 on May 5, 2011, at 0400 hours was inaccurate.
23. On May 5, 2011, Patient 765346 was admitted for post-surgical observation. This patient was a "fresh post-op patient with anesthesia on board," indicating that the patient was or had been sedated.
24. On May 5, 2011, at 1850 hours, the physician entered a "range order" for pain medication for Patient 765346. The range order provided that if Patient 765346 experienced pain on a range of one-to-four, then Patient 765346 could receive one Norco tablet as needed. If the pain exceeded a pain level of four, then Patient 765346 could receive two Norco tablets as needed. In addition, Patient 765346 could receive Morphine intravenously as needed for breakthrough pain.
25. On May 5, 2011, at 1930 hours, Patient 765346 had no bowel sounds. This patient did not regain bowel sounds during Respondent's shift.
26. Oral medication if given to a patient with no bowel sounds may not be absorbed and may nauseate the patient.
27. On May 5, 2011, at 2220 hours, the physician checked on Patient 765346 by telephone, Respondent told the physician about Patient 765346's condition, and Respondent received orders from the physician over the phone.
28. On May 5, 2011, at 2220 hours, the physician gave a telephone order for Zofran for nausea.
29. On May 5, 2011, at 2300 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders.
30. On May 6, 2011, at 0225 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders.
31. On May 6, 2011, at 0225 hours, the Daily Assessment for Patient 765346 shows that Patient 765346 was medicated because he was complaining of pain.
32. On May 6, 2011, at 0530 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders.
33. On May 6, 2011, at 0530 hours, the Daily Assessment for Patient 765346 shows that Patient 765346 received medication for pain.

34. On June 3, 2011, Patient 769379 was admitted to the hospital with symptoms of a transient ischemic attack. The patient had slurred speech and other symptoms. The patient's neurological assessment indicated that the patient also felt flushed, was unsteady, had a slight tingling all over, felt hazy, and was off in a fog.
35. Patient 769379's Graphic Sheet Intake and Output record shows that the patient maintained an oxygen saturation level of 100% at each 4-hour assessment, except for 97% at 2000 hours on June 3, 2011, and a 99% saturation level at 1200 hours on June 4.
36. On June 3, 2011, at 2300 hours, the family of Patient 769379 expressed concerns to Respondent that Patient 769379 was not alert anymore. Respondent performed a neurological check and documented that Patient 769379 was hesitant in speech and "felt weird."
37. Respondent administered oxygen and, after a few minutes on the oxygen, Patient 769379 was alert, active, cheerful, and spontaneous. Respondent documented this information in Patient 769379's Daily Assessment on June 3, 2011, at 2300 hours.
38. On June 3, 2011, at 2300 hours, the physician was on the floor at the time Patient 769379 was experiencing a decreased level of consciousness. Respondent stopped the physician in the hall and told her about the patient's condition.
39. The physician went into the patient's room and made her own assessment of the patient's condition after Respondent had put the patient on oxygen.
40. On June 3, 2011, at 2300 hours, Respondent documented Patient 769379's symptoms and communicated this information to the physician.
41. Patient 769379 did not suffer a negative outcome and was discharged the next day.
42. On Patient 775249's Daily Assessment form for August 11, 2011, Respondent did not check the boxes on the Daily Assessment regarding Patient 775249's cardiovascular system, pain, gastro-genitourinary system, nutrition/feeding, wound, and skin integrity. These conditions were not related to the health reasons for which Patient 775249 was hospitalized.
43. On Patient 775249's Daily Assessment form for August 11, 2011, Respondent checked the boxes on the Daily Assessment form regarding Patient 775249's neurological system, pulmonary system, musculoskeletal system, fall risk assessment, and IV site.
44. Respondent did not complete the August 11, 2011 Daily Assessment form for Patient 775249.
45. On November 14, 2000, the Board issued an order to address conduct related to a home health agency owned by Respondent. The Board issued the sanction of Reprimand with Stipulations. The Board required Respondent to complete nursing courses in

- jurisprudence, documentation, and ethics. The Board required indirect supervision of Respondent for 1 year.
46. On November 13, 2006, the Board issued an order to address Respondent's failure to provide CPR to a patient in 2005. The Board issued the sanction of Reprimand with Stipulations. Respondent's license was suspended for 1 year, and that suspension was stayed and Respondent placed on probation for 2 years. Respondent was ordered to complete nursing courses in jurisprudence, ethics, and basic cardiopulmonary life support for healthcare providers. The Board required indirect supervision of Respondent for 2 years.
 47. On August 17, 2010, the Board issued an order addressing Respondent's failure to notify a physician that a patient had fallen on the floor and had sustained a scalp hematoma, thereby depriving the physician of essential information. Respondent received a Warning with Stipulations, including the requirements to take nursing courses in jurisprudence, ethics, and sharpening critical thinking skills. The Board required indirect supervision of Respondent for 1 year.
 48. On July 11, 2013, Staff mailed its Amended Notice of Hearing to Petitioner with the Formal Charges.
 49. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.
 50. Administrative Law Judge Kerrie Jo Qualtrough convened the hearing on the merits on October 1, 2013, at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel John R. Griffith represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on October 1, 2013.

VI. CONCLUSIONS OF LAW

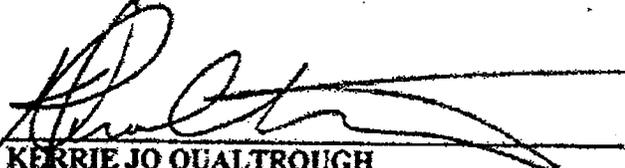
1. The Board has jurisdiction to govern the practice of nursing in Texas. Tex. Occ. Code ch. 301.
2. SOAH has jurisdiction to conduct formal hearings in matters involving alleged violations. Tex. Occ. Code § 301.459(a); Tex. Gov't Code ch. 2003.
3. The notice of the hearing met the requirements of Texas Occupations Code § 301.454, Texas Government Code §§ 2001.051 and 2001.052, and 1 Texas Administrative Code § 155.401.
4. A person is subject to disciplinary action for a violation of the Texas Occupations Code or a Board rule. Tex. Occ. Code § 301.452(b)(1).

5. A person is subject to disciplinary action for failing to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm. Tex. Occ. Code § 301.452(b)(13).
6. The Board has adopted standards that establish minimum levels of acceptable nursing practice. 22 Tex. Admin. Code § 217.11.
7. The Board's nursing standards require all nurses to accurately and completely report and document: the patient's status including signs and symptoms; nursing care rendered; physician orders; administration of medications and treatments; patient responses; and contacts with other health care team members concerning significant events regarding patient's status. 22 Tex. Admin. Code § 217.11(1)(D).
8. Respondent failed to accurately and completely report and document the status of Patients 765728 and 775249. 22 Tex. Admin. Code § 217.11(1)(D)
9. Respondent failed to accurately and completely report and document the administration of medications to Patient 765567. 22 Tex. Admin. Code § 217.11(1)(D).

VII. RECOMMENDATION

The ALJ recommends that Respondent should receive a Reprimand with Stipulations, including the requirements that Respondent should take certain nursing courses related to documentation and that she be subject to indirect supervision for 3 years.

SIGNED November 20, 2013.



KERRIE JO QUALTROUGH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS



Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.texas.gov

Katherine A. Thomas, MN, RN, FAAN
Executive Director

December 5, 2013

The Honorable Kerrie Jo Qualtrough, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Via Electronic Filing

Re: In the Matter of Permanent License No. 510065
Issued to JAN E. BROWN
SOAH Docket No. 507-13-5024

Dear Judge Qualtrough:

Enclosed please find Staff's Exceptions to Proposal for Decision.

By copy of this letter, I am forwarding a copy of this document to Respondent's counsel.

Please feel free to contact me at (512) 305-8658 should you have any questions and/or concerns regarding this case.

Thank you in advance for your time and assistance with this matter.

Very truly yours,

[Handwritten signature of John R. Griffith]

John R. Griffith
Assistant General Counsel

JRG:cll
Enclosure

cc: Marc Meyer, Attorney
Law Office of Marc Meyer, PLLC
33300 Egypt Lane, Suite B-200
Magnolia, TX 77354-2739

Via Facsimile: (866) 839-6920 &
Certified Mail, Address Service Requested,
No. 91 7199 9991 7031 6341 4201

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Graubury Weatherford El Paso Bryan Lubbock

IN THE MATTER OF
PERMANENT REGISTERED NURSE
CERTIFICATE NUMBER 510065
ISSUED TO
JAN E. BROWN, RN,
RESPONDENT

§
§
§
§
§
§

BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW, Staff of the Texas Board of Nursing ("Staff" or "the Board"), by and through its attorney of record, John R. Griffith, and files exceptions to the Proposal for Decision issued in this matter on November 20, 2013, and would state as follows:

I.

Staff excepts to the proposed Finding of Fact No. Twenty-Four (24):

24. "On May 5, 2011, at 1850 hours, the physician entered a "range order" for pain medication for Patient 765346. The range order provided that if Patient 765346 experienced pain on a range of one-to-four, then Patient 765346 could receive one Norco tablet as needed. If the pain exceeded a pain level of four, then Patient 765346 could receive two Norco tablets as needed. In addition, Patient 765346 could receive Morphine intravenously as needed for breakthrough pain."

Staff excepts to the proposed Finding of Fact with regard to the last sentence: "In addition, Patient 765346 could receive Morphine intravenously as needed for breakthrough pain." "Breakthrough pain," as provided in the physician's order,¹ and as Ms. Cone testified, was prescribed for pain that two tablets of Norco could not relieve. The physician's order required that either one or two tablets of Norco, per the Patient's pain level, be administered *before* any Morphine for breakthrough pain. "Breakthrough pain" is only the pain that Norco could not relieve, and thus, Respondent was required to first administer the Norco, per the order. The Morphine was not simply "as needed," but rather was to be administered "as needed" or "PRN" *after* the Norco proved insufficient.

Therefore, Staff respectfully requests the ALJ amend the PFD by properly changing Finding of Fact No. Twenty-Four (24) to read as follows:

24. "On May 5, 2011, at 1850 hours, the physician entered a "range order" for pain medication for Patient 765346. The range order provided that if Patient 765346 experienced pain on a range of one-to-four, then Patient 765346 could receive one Norco tablet as needed. If the pain exceeded a pain level of four, then Patient 765346 could receive two Norco tablets as

¹ Staff's Ex. 13 at 523.

needed. In addition, if the patient's pain persisted after the administration of Norco, 765346 could receive Morphine intravenously, as needed, for breakthrough pain."

II.

Staff excepts to the following proposed Findings of Fact Nos. Twenty-Nine (29), Thirty (30), and Thirty-Two (32):

29. "On May 5, 2011, at 2300 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders."
30. "On May 6, 2011, at 0225 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders."
32. "On May 6, 2011, at 0530 hours, Respondent administered Morphine to Patient 765346 pursuant to the physician's orders."

Neither the physician's original order,² nor the subsequent 2220 Telephone Order,³ direct Respondent to administer Morphine *prior* to the administration of Norco. Ms. Cone testified to this fact, and the orders themselves are supported the Nurse's Notes⁴ in that Respondent did not document anything regarding being ordered to administer Morphine *before* administering Norco. There is zero documentary evidence to support Respondent's actions.

At hearing, Respondent's testified, as noted by the ALJ, that "...Respondent testified that she would have discussed the patient's pain medication with the physician during that telephone call."⁵ However, this contradicts both Respondent's testimony at hearing and Respondent's Response to Petitioner's Request for Disclosure, specifically, Charge III. First, at hearing, Respondent testified, as noted by the ALJ, that she "...made the judgment call to give the Morphine intravenously because of this patient's nausea and lack of bowel sounds."⁶ Moreover, at hearing, Respondent claimed on cross-examination that she did not need to consult with the physician.⁷ In fact, Respondent, at hearing, was confused about the Order itself, claiming that she thought she could give the Norco *or* the Morphine.⁸ After having the Order explained to her, Respondent admits to not following it.⁹ And still, Respondent maintained that she believes it was a "nursing judgment call."¹⁰

In her Response to Petitioner's Request for Disclosure,¹¹ Respondent admitted that:

"The assessment of pain and choice of medication is a somewhat subjective exercise that while guided by the physician's order is also subject to nursing judgment. For this

² Id.

³ Staff's Ex. 13 at 524.

⁴ Id., at 580.

⁵ PFD at 13.

⁶ Id.

⁷ Hearing Recording at 3:25:10 – 3:26:20.

⁸ Id.

⁹ Id., at 3:26:00 – 3:26:20.

¹⁰ Id., at 3:26:25 -3:26:45.

¹¹ Staff's Ex. 15 at 2.

patient, freshly out of surgery and apparently nauseated, oral medication, such as Norco, would be contraindicated and IV Morphine would be the appropriate choice.”

The ALJ does **NOT** making a Finding of Fact that the physician order Respondent to give Morphine instead of Norco. But in the ALJ’s analysis of Formal Charge III, the ALJ states:

“A full review of the evidence corroborates Respondent’s testimony that she informed the physician of the lack of bowel sounds and he authorized her by telephone to administer the Morphine intravenously, as already authorized for breakthrough pain in the range order.”¹²

The ALJ goes on to find that “...Respondent was authorized to administer the Morphine intravenously, which she did, as indicated on the MAR and the Daily Assessment. The ALJ concludes that Staff did not meet its burden of proof on Charge III.”¹³

Staff completely rejects the ALJ’s reasoning because it is in conflict with the facts of the case. Beyond Respondent’s own confusion about the order, and her belief that her “nursing judgment” could be used instead of the physician’s, Respondent actual admits that she does **NOT REMEMBER** discussing giving the Morphine instead of the Norco with the physician when she spoke to him about the Zofran.¹⁴ Further, Respondent first claims she does not remember, but then admits there is not any discussion of Morphine on the Telephone Order or in the Nurse’s Notes.¹⁵ At one point, Respondent claims she doesn’t even know if she documented any discussion of Morphine during her call with the physician.¹⁶

Listening to the cross-examination,¹⁷ there is no doubt that Respondent admits she does not remember talking to the physician about Morphine. And given the fact that in her disclosures she relied on “nursing judgment,” and at hearing also relied on her “nursing judgment” over the judgment of the physician, her novel passing notion that she may/might have discussed it with the physician has no merit. Respondent clearly has no memory of a conversation about Morphine with the physician, and anything beyond that is mere speculation on her part. It is also clear, that at hearing, Respondent was still confused about the order itself. Respondent also has an incorrect notion that somehow a “nursing judgment call” can override a physician’s order, despite the fact the physician was obviously available for consultation.

Here, twice Respondent admits to substituting her judgment for that of the physician. Only at hearing, does Respondent provide the convenient, and questionable, justification via that “...she would have discussed the patient’s pain medication with the physician during that telephone call” at 2220 hours.¹⁸ As discussed above, Respondent does not even remember discussing Morphine with the physician. Thus, Respondent’s justification is questionable not only given her credibility issues due to bias and past misconduct, but also given that neither in the 2220 telephone order, nor in the nursing notes, can any mention of a physician’s order to administer Morphine *before* Norco be found. Instead, what Respondent presented in both her Response to Petitioner’s Request for Disclosure, and at hearing, is that she exercised her “nursing

¹² PFD at 14.

¹³ Id., at 15.

¹⁴ Hearing Record at 3:29:05 -3:29:40. See also Hearing Record 3:27:30 – 3:34:30.

¹⁵ Id., at 3:29:30 – 3:34:30.

¹⁶ Id., at 3:29:30 – 3:30: 20.

¹⁷ Id., at 3:25:00 – 3:34:30.

¹⁸ PFD at 13.

judgment," which she used to make the determination that Morphine, not the physician ordered Norco, was the proper medication to administer.

There is no documentation that supports Respondent's story, which she herself contradicts in her Response to Disclosures and at hearing. In sum, given Respondent's admittedly not remembering any discussion with the physician about Morphine, and her prior admissions in discovery, plus her testimony at hearing, and the complete absence of an order to supersede the prior physician's order, the preponderance of the evidence suggests Respondent administered Morphine in violation of the physician's order. Any claim by Respondent to the contrary is either blatant speculation or a fabrication.

Therefore, Staff respectfully requests the ALJ amend the PFD by properly changing the above proposed Findings of Fact Nos. Twenty-Nine (29), Thirty (30), and Thirty-Two (32) to reflect the following:

29. "On May 5, 2011, at 2300 hours, Respondent administered Morphine to Patient 765346 in violation of the physician's order."
30. "On May 6, 2011, at 0225 hours, Respondent administered Morphine to Patient 765346 in violation of the physician's order."
32. "On May 6, 2011, at 0530 hours, Respondent administered Morphine to Patient 765346 in violation of the physician's order."

III.

Staff excepts to the following proposed Findings of Fact Nos. Thirty-Eight (38), Thirty-Nine (39), and Forty (40):

38. "On June 3, 2011, at 2300 hours, the physician was on the floor at the time Patient 769379 was experiencing a decreased level of consciousness. Respondent stopped the physician in the hall and told her about the patient's condition."
39. "The physician went into the patient's room and made her own assessment of the patient's condition after Respondent had put the patient on oxygen."
40. "On June 3, 2011, at 2300 hours, Respondent documented Patient 769379's symptoms and communicated this information to the physician."

All of the three Findings of Fact above are based on Respondent's testimony that the physician was on the floor at the time of the incident, and Respondent communicated with the physician regarding the patient's condition and the use of oxygen.¹⁹ Respondent also testified at hearing that the physician went into the patient's room and made her own assessment of the patient's condition after Respondent had put the patient on oxygen.²⁰

¹⁹ PFD at 17.

²⁰ Id.

The ALJ, in her Analysis of Charge IV, believes Respondent, and writes that since Respondent "...consulted with the physician, and the physician examined the patient...the physician was not deprived of information necessary to care for the patient."²¹ The merit given to Respondent's testimony is unwarranted. As the ALJ notes, the patient's oxygen saturation levels at the time of the incident "do not appear in the record..."²²

Ms. Cone testified, and the ALJ noted, that the failure to document the oxygen saturation levels before or after administering oxygen deprived the physician of essential information on which to base future care.²³ First, how did Respondent know it was appropriate to administer oxygen if she did not check the oxygen saturation level? The ALJ notes the pre-oxygen oxygen saturation level was neither documented on the Graphic Sheet Intake and Output Record, nor on the Daily Assessment.²⁴ The ALJ also notes the post-oxygen saturation level was not documented on the Graphic Sheet Intake and Output Record or Daily Assessment.²⁵ Second, since this information was not documented, even if one believes Respondent's unsupported story that the physician was present and consulted, how could Respondent provide the appropriate information without having taken the oxygen saturation levels? The evidence suggests Respondent did not actually consult with the physician.

Nothing in the Daily Assessment²⁶ or medical record indicates Respondent ever consulted with the physician. How could she have even done so without knowing the oxygen saturation levels? And if she had that information, why did she fail to document it? When questioned at hearing, Respondent could not recall the female physician's name that she allegedly spoke with. In Respondent's June 3rd, 2300, Daily Assessment/Observation Record note, Respondent does not mention any consultation with the physician.²⁷ This omission is inconsistent with Respondent's practice of documenting physician consultation, such as with the telephone order regarding medication for nausea.²⁸ With the physician consultation regarding Formal Charge III, Respondent documented the telephone order conversation on the Physician Admission Orders²⁹ and the May 5th, 2220, Daily Assessment/Observation Record note. Thus, it appears Respondent does sometimes document her consultation with physicians, despite her statement that she "does not document for doctors."³⁰ Further, even if one believes Respondent's questionable testimony regarding physician consultation, Respondent then failed to even document the results of the alleged assessment done by the unknown physician.

Staff cannot accept the analysis that "she doesn't document for doctors" as accurate or authoritative. As discussed, Respondent's practice contradicts this claim. Thus, Staff cannot accept the ALJ's analysis based on Respondent's unsupported testimony.

In sum, the evidence does not support Respondent's contention that she notified the physician of the change in condition of Patient 769379. In fact, there is no evidence beyond Respondent's own unsupported testimony that a physician was even consulted at all.

²¹ Id., at 18.

²² Id.

²³ Id., at 16.

²⁴ Id., at 15-16. See also, Staff's Ex. 13 at 673 and 690.

²⁵ Id., at 15-16. See also, Staff's Ex. 13 at 673 and 690.

²⁶ Staff's Ex. 13 at 690.

²⁷ Id.

²⁸ See Staff's Ex. 13 at 580 and 524.

²⁹ Staff's Ex. 13 at 524.

³⁰ PFD at 17.

Therefore, Staff respectfully requests the ALJ amend the PFD by properly changing the above proposed Findings of Fact Nos. Thirty-Eight (38), Thirty-Nine (39), and Forty (40) to reflect the following:

38. "On June 3, 2011, at 2300 hours, Patient 769379 was experiencing a decreased level of consciousness, tingling in the hands, and hesitant speech. Respondent failed to notify the physician of the patient's condition."
39. Delete Finding of Fact Thirty-Nine (39).
40. "On June 3, 2011, at 2300 hours, Respondent documented Patient 769379's symptoms but failed to communicate this information to the physician."

In the alternative, after consideration of the above and the evidence, should the ALJ still believe Respondent's story that she consulted with the physician, then Staff respectfully requests the ALJ to add a Finding of Fact regarding Respondent's undisputed failure to document the oxygen saturation of Patient 769379.

Formal Charge IV not only alleges that Respondent failed to notify the physician, but also that Respondent failed to document the oxygen saturation before and after the intervention. To Staff's recollection, Respondent has never denied failing to document the oxygen saturation before and after the intervention.³¹ The record is clear that Respondent did not document the oxygen saturation.³² The preponderance of the evidence supports a Finding of Fact based on Formal Charge IV that Respondent failed to document the oxygen saturation before and after the intervention, as appropriate and required.

Therefore, Staff respectfully requests, in the alternative, the ALJ amend the PFD by properly adding the proposed Finding of Fact, as follows:

"On June 3, 2011, Respondent failed to accurately and completely report and document the oxygen saturation of Patient 769379 before and after the intervention, as appropriate and required."

IV.

Staff excepts to Conclusion of Law No. Eight (8):

8. "Respondent failed to accurately and completely report and document the status of Patients 765728 and 775249. 22 Tex. Admin. Code § 217.11(1)(D)."

In all three cases, the ALJ found Respondent failed to meet the minimum acceptable standards of nursing. The ALJ cited the Board's Rule, but Respondent also violated Texas Occupations Code

³¹ See Staff's Ex. 15. Respondent does not claim she documented the oxygen saturation levels before or after the intervention.

³² PFD at 15-16, and 18. See also, Staff's Ex. 13 at 673 and 690.

§ 301.452(b)(13) by failing to conform to the minimum standards of acceptable nursing practice. Board Rule § 217.11 provides the minimum standards of acceptable nursing practice for all nurses. The ALJ found Respondent in violation of § 217.11(1)(D).

Regarding Charge I, and Patient 765728, the ALJ found Respondent failed to indicate the proper Fall Risk Level in the proposed Findings of Fact Nos. Four (4) through Six (6). Respondent's unprofessional conduct violated Texas Occupations Code § 301.452(b)(10) in that such conduct was likely to injure patients. Per the Board's Disciplinary Matrix (Board Rule 213.33(b)), a first tier offense can simply consist of an "[i]solated failure to comply with Board rules regarding unprofessional conduct resulting in unsafe practice with no adverse patient effects." Failing to properly document can injure patients. Luckily, there were no adverse patient effects other than creating a low risk of harm. Nonetheless, Respondent violated Texas Occupations Code § 301.452(b)(10).

Additionally, Respondent's unprofessional conduct violated Board Rules § 217.12(1)(B)&(4) because Respondent's "carelessly" failed to conform to nursing standards, and also was "careless" in that Respondent's conduct endangered the patient's life, health or safety. Per Rule 217.12, actual injury need not be established. Further, when looking at Respondent's overall pattern of misconduct, Respondent did in fact "repeatedly fail" to conform to generally accepted nursing standards.

Staff contends, as Ms. Cone testified,³³ that an inaccurate record creates a risk of harm. While the risk of harm may have been low with Patient 765728, low risk is still risk, and such an error could certainly expose patients unnecessarily to a risk of harm. As such, Respondent also violated Texas Occupations Code § 301.452(b)(13) and Board Rules § 217.12(1)(B)&(4).

Regarding Charge V, and Patient 775249, Findings of Fact Nos. Forty-Three (43) and Forty-Four (44) indicate Respondent did not complete the August 11, 2011, Daily Assessment form for Patient 775249. The ALJ found Patient 775249's records are incomplete, and that Respondent did not accurately and completely report and document the patient's status.³⁴ However, on page 21 of the Proposal for Decision (PFD), the ALJ writes, "The evidence is insufficient to show that the failure to check boxes created or had the potential to create an unsafe environment for this patient." Therefore, the ALJ concluded that Respondent did not violate Board Rule § 217.11(1)(B). This conclusion conflicts with Ms. Cone's testimony, noted by the ALJ on page 19 of PFD. Ms. Cone testified that a patient is put at risk if a nurse fails to ask the questions and document the answers.³⁵ When this happens, patient complaints go without necessary medical intervention, and subsequent nursing shifts will not have a complete picture of the patient's condition and/or changes to the patient's condition.³⁶ This deprives the patient of continuity of care.³⁷ The simple truth that Respondent failed to document the patient's status proves she failed to implement measures or promote a safe environment for the patient. The "potential" to create an unsafe environment for the patient was demonstrated at hearing, and thus, Respondent also violated § 217.11(1)(B).

Respondent's conduct also violated § 217.12(1)(B)&(4) and Tex. Occ. Code § 301.452(b)(10). Per both Rules, Respondent's unprofessional conduct resulted from her

³³ See PFD at 4.

³⁴ PFD at 21; Findings of Fact Nos. Forty-Three (43) and Forty-Four (44).

³⁵ PFD at 19.

³⁶ Id.

³⁷ Id.

"careless" behavior. The potential for harm, as discussed above, did exist, but no actual harm is necessary to prove a violation under the Rules. Under § 301.452(b)(10), Respondent's unprofessional conduct violated the Board's Rules and resulted in unsafe practice that created a risk of harm, but no other adverse patient effects.

And while the ALJ argues Respondent's conduct did not constitute unsafe practice, per § 217.12(1)(B)&(4),³⁸ the reasoning is misguided. First, the ALJ believes that somehow since the reason for admission was not directly related to the unchecked boxes that that constitutes proper mitigation for Respondent.³⁹ While the reason for admission may not directly relate to the unchecked boxes, that does not excuse a nurse from failing to assess a patient's cardiovascular system, gastro-genitourinary system, skin integrity, pain, nutrition/feeding status, and wounds. Respondent also failed to document any assessment in her handwritten notes.⁴⁰ Second, the ALJ also relies upon two other errors in the medical records to support Respondent's claim that this was a minor mistake that other nurses make. Reliance on the notion that since other nurses commit the same errors might be appropriate as a matter in mitigation, but it does not negate a finding that Respondent committed unprofessional conduct in violation of Board Rules. Analogous to a speeding ticket situation where a defendant argues that everyone else was speeding, but the police officer wrongfully pulling him or her over was unfair, a defense of selective prosecution does not excuse the misconduct. Further, the evidence demonstrates not only was Respondent "careless" in her documentation and failure to perform an assessment, but also that both a failure to assess and/or document an assessment creates a danger to a patient's life, health, or safety. Respondent violated Board Rules § 217.12(1)(B)&(4) and Tex. Occ. Code § 301.452(b)(10).

Therefore, Staff respectfully requests the ALJ amend the PFD by modifying the Conclusions of Law by separating the two patients referenced in Conclusion Eight (8) and creating a new Conclusion of Law, as follows:

8. "Respondent failed to accurately and completely report and document the status of Patient 765728 in violation of Tex. Occ. Code § 301.452(b)(10)&(13) and 22 Tex. Admin. Code § 217.11(1)(B)&(1)(D) and 22 Tex. Admin. Code § 217.12(1)(B)&(4)."

Create a new Conclusion of Law:

"Respondent failed to accurately and completely report and document the status of Patient 775249 in violation of Tex. Occ. Code § 301.452(b)(10)&(13) and 22 Tex. Admin. Code § 217.11(1)(B)&(1)(D) and 22 Tex. Admin. Code § 217.12(1)(B)&(4)."

V.

Staff excepts to Conclusion of Law No. Nine (9):

³⁸ Id., at 21.

³⁹ Id.

⁴⁰ Id.

9. "Respondent failed to accurately and completely report and document the administration of medications to Patient 765567. 22 Tex. Admin. Code § 217.11(1)(D).

The ALJ found Respondent did not accurately and completely document the administration of medications in violation of § 217.11(1)(D).⁴¹ Staff contends Respondent also violated § 217.11(1)(B). Ms. Cone testified, and clearly explained, that an accurate MAR is necessary for proper patient care, and that Respondent's documentation error could have resulted in the patient not receiving pain medication for sixteen (16) hours.⁴² In this case, Respondent admits that she did not give the Tramadol because the patient was asleep.⁴³ And despite not administering the medication, Respondent still indicated on the MAR that she did. This created a situation just as Ms. Cone described where subsequent nurses would believe the patient received the medication at 0400 hours. As such, the patient could have gone without pain medication for sixteen (16) hours. The ALJ notes the Accudose Report confirms the medication was not pulled at 0400, and this is further confirmed by Respondent's employee record.⁴⁴ There is no doubt Respondent failed to implement measures to promote a safe environment for the patient. Respondent violated § 217.11(1)(B).

Respondent's conduct also violated § 217.12(1)(B)&(4). Per both Rules, Respondent's unprofessional conduct resulted from her "careless" behavior. While no harm is necessary to prove a violation under the Rules, the patient may have gone without pain medication for sixteen (16) hours. At the very least, the exact risk Ms. Cone described was created by Respondent's failure.

Respondent's conduct also violated Texas Occupations Code § 301.452(b)(10). Respondent's error was both unprofessional and likely to injure the patient, as discussed above.

Therefore, Staff respectfully requests the ALJ amend the PFD by properly including the amended Conclusion of Law, as follows:

9. "Respondent failed to document the administration of Tramadol to Patient Medical Record Number 765567 at 04:00 in violation of Tex. Occ. Code § 301.452(b)(10)&(13) and 22 Tex. Admin. Code §§ 217.11(1)(B)&(D) and 217.12(1)(B)&(4)."

VI.

Staff excepts to the absence of the following Conclusion of Law:

"Respondent failed to administer Norco 10/325 by mouth every 4 hours, 1 tab for pain<4, 2 tabs>4, to Patient Medical Record Number 765346 as ordered by the physician. Instead, Respondent administered Morphine to the patient, which was order only for break through pain, in violation of Tex. Occ. Code §

⁴¹ Id., at 10. See also Finding of Fact No. Twenty-Two (22).

⁴² Id., at 7.

⁴³ See Staff's Ex. 15.

⁴⁴ PFD at 10; Staff's Ex. 7 at 60; Staff's Ex. 5 at 43.

301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B)&(1)(C) and 217.12(1)(B)&(4).”

As discussed above regarding Exception II, and based on the proposed amended Findings of Fact Nos. Twenty-Nine (29), Thirty (30), and Thirty-Two (32), Respondent administered Morphine to Patient 765346 without a physician’s order. Respondent exceeded her scope of practice when she intentionally, or at least carelessly, failed to follow the physician’s order. Respondent deprived the patient of the opportunity to see if Norco would be sufficient to treat his pain. As such, and per the prior discussion regarding the Findings of Fact, Respondent violated Tex. Occ. Code § 301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B)&(1)(C) and 217.12(1)(B)&(4).

Therefore, Staff respectfully requests the ALJ amend the PFD by properly including the above proposed Conclusion of Law.

VII.

Staff excepts to the absence of the following Conclusion of Law:

“Respondent failed to notify the physician of a change in the condition of Patient medical Record Number 769379 when the patient experienced a decreased level of consciousness, tingling in the hands, and hesitant speech. Instead, Respondent administered oxygen to the patient without documenting the patient’s oxygen saturation before and after the intervention, as appropriate and required, in violation of Tex. Occ. Code § 301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B), (1)(D)&(1)(P) and 217.12(1)(B)&(4).”

As discussed above regarding Exception III, and based on the proposed amended Findings of Fact Nos. Thirty-Eight (38), Thirty-Nine (39)(recommended to be deleted), and Forty (40), Respondent failed to notify the physician of the patient’s condition when the patient was experiencing a decreased level of consciousness, tingling in the hands, and hesitant speech. Respondent’s conduct violated Tex. Occ. Code § 301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B), (1)(D)&(1)(P) and 217.12(1)(B)&(4).

Therefore, Staff respectfully requests the ALJ amend the PFD by properly including the above proposed Conclusion of Law.

In the alternative, if the despite the discussion of Exception III, the ALJ believes Respondent’s story that she did collaborate and notify the physician, then at the very least, Staff excepts to the absence of the following Conclusion of Law:

“On June 3, 2011, Respondent failed to accurately and completely report and document the oxygen saturation of Patient 769379 before and after the intervention, as appropriate and required, in violation of Tex. Occ. Code § 301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B)&(1)(D) and 217.12(1)(B)&(4).”

As discussed above regarding Exception III, as an alternative to the proposed amended Findings of Fact Nos. Thirty-Eight (38), Thirty-Nine (39)(recommended to be deleted), and Forty (40), the proposed Conclusion of Law accurately reflects Respondent’s failure to accurately and

completely report and document the oxygen saturation of the patient in question. Respondent's failure to document violated Tex. Occ. Code § 301.452(b)(10)&(13), and 22 Tex. Admin. Code §§ 217.11(1)(B)&(1)(D) and 217.12(1)(B)&(4).

Therefore, as an alternative, Staff respectfully requests the ALJ amend the PFD by properly including the above proposed Conclusion of Law.

VIII.

Staff excepts to the recommended sanction of a Reprimand with Stipulations with nursing courses and three (3) years of indirect supervision.

First, while Staff asserts Respondent did violate Tex. Occ. Code § 301.452(b)(10) and 22 Tex. Admin. Code § 217.12, as discussed above, analysis under the Disciplinary Matrix, per Tex. Occ. Code § 301.452(b)(13), is appropriate given the nature of the offenses.

Second, while the ALJ summarizes Staff's recommend sanction as a Tier 2, Sanction Level 1 sanction, this was not the sanction recommended by Ms. Cone or Staff.⁴⁵ If Staff or Ms. Cone said "Sanction Level 1," that was in error. The nature of the sanction argued for, and summarized by the ALJ,⁴⁶ includes a three (3) year suspension, with the suspension enforced until Respondent completes a nursing refresher course, as Ms. Cone explained at hearing. The ALJ properly summarizes the additional requirements recommended by Ms. Cone.⁴⁷ Such a sanction under the Disciplinary Matrix § 301.452(b)(13) must be a Second Tier, Sanction Level II offense.

Third, while Staff asserts Respondent violated the Nursing Practice Act and Board Rules as alleged in all five Formal Charges, even only finding violations under Formal Charges I, II and V, a Second Tier, Sanction Level II offense. Staff offers that the risk of harm rose above a First Tier "low risk" of harm. Staff contends Respondent not only committed documentation errors, but also failed to follow orders,⁴⁸ prevented a patient from receiving timely pain medication,⁴⁹ failed to notify a physician about a change in condition,⁵⁰ and completely failed to perform and/or document critical assessment information.⁵¹ The lack of actual harm does not negate the real potential for harm, as Ms. Cone discussed regarding each separate allegation. Not receiving pain medication for sixteen (16) hours, failing to notify a physician after a patient has a decreased level of consciousness, tingling in the hands, and hesitant speech (while not even documenting the oxygen saturation at all), and not performing and/or document critical assessment information created the risk for actual harm. Just looking at Formal Charge II, the potential for a patient to be denied pain medication for sixteen (16) hours is not a "low risk" of harm. And when a decreased level of consciousness, including the oxygen saturation level, goes unreported and/or undocumented, future physicians and medical staff have nothing to base their future care. These failures alone constitute a real "risk of patient harm" as a Second Tier Offense.

⁴⁵ PFD at 23.

⁴⁶ Id.

⁴⁷ Id.

⁴⁸ Formal Charge III

⁴⁹ Formal Charge II

⁵⁰ Formal Charge IV

⁵¹ Formal Charge V

Fourth, Staff agrees with the ALJ's assessment that the aggravating factors warrant an increased sanction under Sanction Level II.

Fifth, Staff specifically disagrees with the ALJ that indirect supervision is sufficient. Given the three prior Board Orders, Staff asserts direct supervision is necessary, as Ms. Cone recommended at hearing. Staff wants to clarify exactly what direct supervision would require, per Board Rule 217.1(10):

(10) Direct supervision—Requires a nurse to be immediately available to coordinate, direct, and observe at firsthand another individual for whom the nurse is responsible.

Additionally, the direct supervision stipulation language that would be included in any Order would provide:

“For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, 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.”

Board Rule 217.1(18) provides a definition for indirect supervision:

(18) Indirect supervision—Requires a nurse to be readily available if needed for consultation to coordinate, direct, and observe another individual for whom the nurse is responsible.

Additionally, the indirect supervision stipulation language that would be included in any Order would provide:

“For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as 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.”

At hearing, Ms. Cone used the phrase, as the ALJ noted,⁵² "shoulder-to-shoulder" supervision. While under direct supervision a nurse would be on the same "unit" and "immediately available" to provide assistance and/or guidance. Under indirect supervision, the supervising nurse simply needs to be "readily available" and "on the premises." The nurse would not be required to be on the same unit or ward, but merely on the "facility grounds." Practically, a supervising nurse could be on a completely different floor of a hospital and only provide assistance and intervention if necessary.

Clearly, direct supervision is not necessarily true "shoulder-to-shoulder" supervision, but it does demand more supervision than only having someone "on the premises." Therefore, Staff respectfully requests that regardless of any changes to the Findings of Fact and Conclusions of Law, that the ALJ amend her recommended sanction to specifically include one year of direct supervision.

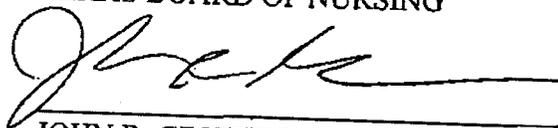
Sixth, and finally, Staff requests the ALJ amend her recommended sanction to conform to Ms. Cone's recommendation of a suspension.

IX. PRAYER

WHEREFORE PREMISES CONSIDERED, Staff requests that the ALJ amend the PFD Conclusions of Law as stated above. Additionally, Staff requests the ALJ recommend the sanction of a Suspension, consistent with Ms. Cone's recommendation at the formal hearing.

Respectfully submitted,

TEXAS BOARD OF NURSING



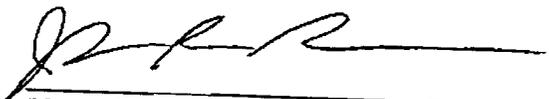
JOHN R. GRIFFITH, Assistant General Counsel
State Bar No. 24079751
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
Ph: (512) 305-8658; Fax: (512) 305-8101

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Staff's Exceptions to Proposal for Decision* was sent via Certified Mail, Address Service Requested, on December 5, 2013, to:

Marc Meyer, Attorney
Law Office of Marc Meyer, PLLC
33300 Egypt Lane, Suite B-200
Magnolia, TX 77354-2739

Via Facsimile: (866) 839-6920 &
Certified Mail, Address Service Requested,
No. 91 7199 9991 7031 6341 4492



JOHN R. GRIFFITH
Assistant General Counsel

⁵² PFD at 26.

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Law Office of Marc Meyer, PLLC

Texas Nursing & EMS Lawyer

Marc M. Meyer, RN, LP, MS, JD Principal Office, Magnolia, TX

December 20, 2013

To: Docketing, State Office of Administrative Hearings
John Griffith, Assistant General Counsel, Texas Board of Nursing

Re: In the Matter of Permanent Certificate Number 511065 Issued to Jan E. Brown

Please see the attached reply to the Texas Board of Nursing's Exceptions to the Proposal for Decision. If you have any questions, please call me at (281) 259-7575. Thank you.

Marc M. Meyer, RN, JD
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DOCKET NO. 507-13-5024

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 510065
ISSUED TO JAN E. BROWN,
RESPONDENT

§
§
§
§
§

BEFORE THE TEXAS STATE
OFFICE OF ADMINISTRATIVE HEARINGS

RESPONDENTS REPLY TO STAFF'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Jan E. Brown, through his attorney, to file this reply to Staff's Exceptions to the Proposal for Decision.

REPLY TO STAFF'S EXCEPTIONS

Finding of Fact No. Twenty-Four (24): In the first exception, Staff complains that the Administrative Law Judge ("ALJ") incorrectly states the physician's order for pain medication for Patient No. 765346. The exception is not supported by the evidence the Board cites. Namely, the order cited by Staff reads "Morphine 2 mg IV Q2hrs PRN breakthrough".¹ Finding of Fact No. Twenty-Four (24) merely repeats the written order, essentially verbatim. By this exception, Staff seeks to add an interpretation of the order that is not supported by a preponderance of the evidence. Ms. Cone's testimony is essentially her interpretation of the order, which differs from the Respondent's interpretation of the order. Staff presents no additional evidence, such as testimony by the physician who wrote the order, to support their interpretation of the order. Therefore, the Respondent asserts that this exception should be denied.

Finding of Fact No. Twenty-Nine (29), Thirty (30) and Thirty-Two (32): In the second exception, Staff complains that the ALJ incorrectly finds that the Respondent administered Morphine pursuant to the physician's orders. Broken down, Staff's argument is that the Respondent did not have the authority to give Patient No. 765346 intravenous Morphine unless she gave the patient Norco by mouth first and therefore the Respondent violated the physician's order. However, as noted by the ALJ, the Respondent was in communication with the physician

¹ Staff's Exhibit 13, at 523.

at 2220, at which time the Respondent received an order for intravenous Zofran for nausea prior to giving the first dose of Morphine.² Staff also argues that the Respondent's "nursing judgment" was improper and cannot override a physician's order. However, the question here is not whether the Respondent overrode a physician's order – she clearly did not – but whether the Respondent properly followed the physician's orders. In her analysis of the evidence surrounding Charge III, the ALJ clearly indicates that she found the evidence compelling that the Respondent was authorized to administer the Morphine based on the order as written. Finding of Fact No. Twenty-Nine (29), Thirty (30) and Thirty-Two (32) merely state that the Respondent gave the medications because of the physician's order, but does not address if the administration of the Morphine was proper. Therefore, the Respondent asserts that this exception should be denied.

Finding of Fact No. Thirty-Eight (38), Thirty-Nine (39) and Forty (40): In the third exception, Staff complains that the ALJ incorrectly finds certain facts related to Charge IV and the Respondent's interaction with the physician for Patient No. 769379. The basis for this exception is essentially that the Respondent's testimony is not believable and unsupported by other evidence.³ However, the ALJ is the finder of fact and has clearly communicated that she found the Respondent to be credible based on the evidence provided and absent any evidence that controverts the Respondent's testimony, Finding of Fact No. Thirty-Eight (38), Thirty-Nine (39) and Forty (40) are reasonable statements of the credible evidence provided by the Respondent's testimony. Therefore, the Respondent asserts that this part of this exception should be denied.

In addition, Staff asserts that an additional finding of fact should be added related to a failure to document oxygen saturation levels prior to and after administration of oxygen.⁴ However, this ignores the fact that the Respondent was routinely documenting oxygen saturation status of the patient, as found in Finding of Fact No. Thirty-Five (35).⁵ The Respondent asserts

² Proposal for Decision, at 14.

³ Exceptions, at 5.

⁴ *Id.*, at 6.

⁵ PFD, at 29.

that the evidence does not define what documentation is "appropriate and required" in this situation. As the ALJ discussed in her analysis of the evidence for Charge IV, the Respondent did document the patient's status both before and after placement of oxygen and testified that the physician was present at the time.⁶ Therefore, the Respondent asserts that this part of this exception should also be denied.

Conclusion of Law No. Eight (8): In the first part of this exception, Staff excepts to the failure of the ALJ to include the violation of TEXAS OCCUPATIONS CODE §301.452(b)(13) in this Conclusion of Law. The Respondent is frankly mystified by this part of the exception as the ALJ clearly stated in Finding of Fact No. Five (5) that a nurse is subject to disciplinary action under Subsection (b)(13) for failing to conform to the minimum standards of nursing, followed by Finding of Fact No. Six (6) that the Board has adopted minimum standards of nursing care in 22 TEXAS ADMINISTRATIVE CODE §217.11(11). A violation of this section was found in Conclusion of Law No. Eight (8) and unless the Respondent is wrong, this means that the ALJ has provided Conclusions of Law which support a finding that the Respondent violated Subsection (b)(13). The Respondent fails to see why Conclusion of Law No. Eight (8) must be changed to add a reference to TEX. OCC. CODE §301.452(b)(13) and thus asserts that this part of this exception should also be denied.

In the rest of this exception, Staff argues that the Respondent also violated Board Rules 217.12(1)(B) & (4) and thus must have also violated TEX. OCC. CODE §301.452(b)(10). The Respondent contends that the ALJ, in discussing the evidence related to both Charge I and Charge V, clearly indicates that the evidence did not support a finding that the Respondent's exhibited "careless or repetitive behavior that may endanger a patient's live, health, or safety" as required by Board Rules Board Rules 217.12(1)(B) & (4).⁷ Nor are there any findings of fact that support this finding. Therefore, the Respondent asserts that this part of this exception should also be denied.

⁶ *Id.* at 17-18.

⁷ *Id.* at 8 & 21.

Conclusion of Law No. Nine (9): In this exception, Staff makes essentially the same arguments as for the exception to Conclusion of Law No. Eight (8). And for the reasons noted *supra* related to the exception concerning Conclusion of Law No. Eight, the Respondent asserts that this exception should be denied.

Proposed Conclusions of Law: In these exceptions, Staff requests two additional Conclusions of Law that Staff asserts are supported by the changes Staff has requested in the Exceptions to Finding of Fact No. Twenty-Four (24), Twenty-Nine (29), Thirty (30), Thirty-Two (32), Thirty-Eight (38), Thirty-Nine (39) and Forty (40). As noted *supra*, the Respondent believes that the ALJ made proper findings of fact that are supported by the evidence and that no additional findings of fact are necessary or appropriate in this matter. Thus, the Respondent asserts that the addition of the proposed Conclusions of Law would be improper and urges the ALJ to deny this exception as well.

Recommendation for Sanction): Staff excepts to the ALJ's recommended sanction as improper, again based extensively on their arguments *supra*, and argues that the Respondent's license should be suspended, with the suspension enforced until the Respondent takes a refresher nursing class. The Respondent, on the other hand, believes that the ALJ's analysis of the recommended sanction is generally proper considering the aggravating and mitigating factors noted by the ALJ in the PFD.⁸ However, the Respondent asserts that it has been the general precedent of the Board that Reprimands are generally for a two (2) year period.⁹ Therefore, the Respondent respectfully requests that the ALJ change the time frame of the Reprimand to comport with Board precedent and recommend a two (2) year reprimand, but make no other changes to the recommended sanctions and therefore deny Staff's final exception as well.

⁸ PFD, at 24-25.

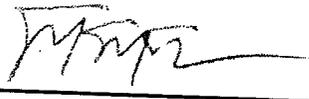
⁹ See e.g. *In the Matter of Permanent Certificate Number 720058 Issued to Peggy Ann Tomlinson*, Docket No. 507-10-1559 (Tex. State Off. Admin. Hearings, June 15, 2010). The proposal for decision in this matter did not define how long the reprimand should last and the Board, in their final order, imposed a two-year reprimand. *In the Matter of Permanent Certificate Number 720058 Issued to Peggy Ann Tomlinson*, Order of the Board, available at [http://lf.hpc.texas.gov/THP/Default.aspx?d=n&q=\[\[Nurse%20Board%20Orders\]:\[license%20number\]=%22720058%22\]](http://lf.hpc.texas.gov/THP/Default.aspx?d=n&q=[[Nurse%20Board%20Orders]:[license%20number]=%22720058%22]) (October 22, 2010). The Respondent searched for further cases where 3 year reprimands were given, but found none of recent vintage.

PRAYER FOR RELIEF

Respondent, Jan E. Brown, prays that the honorable Administrative Law Judge:

1. Make no changes to the Proposal for Decision, Findings of Fact, Conclusions of Law or Recommended Sanctions, except to decrease the time recommended for the Reprimand to a two (2) year period to correspond to prior Board precedent; AND
2. Propose to the Texas Board of Nursing in a Decision all relief at law or in equity to which Respondent is entitled.

Respectfully submitted,

By: 

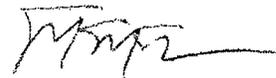
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CERTIFICATE OF SERVICE

This is to certify that on the 20th day of December, 2013, a true and correct copy of the above and foregoing document was served on the following individual(s) at the location(s) and in the manner indicated below:

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 Marc M. Meyer

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

January 13, 2014

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

VIA INTERAGENCY

RE: SOAH Docket No. 507-13-5024; *In the Matter of Jan E. Brown*

Dear Ms. Thomas:

On November 20, 2013, the Administrative Law Judge (ALJ) issued her proposal for decision (PFD) in this matter. On December 5, 2013, the Staff of the Texas Board of Nursing (Board) filed exceptions to the PFD, and Jan E. Brown (Respondent) replied on December 20, 2013. Respondent urged that the Staff's exceptions be denied and also requested a change to the ALJ's penalty recommendation. After reviewing the parties' submissions, the PFD, and the record, the ALJ recommends that the Board overrule Staff's exceptions, but add one additional finding of fact (FOF).

1. Staff Exception I.

Staff excepts to proposed FOF No. 24 regarding the "range order" that prescribed Norco and Morphine for Patient No. 765346. Staff requests that the ALJ revise the finding to reflect that the order prescribed Morphine as needed for breakthrough pain if the pain persisted after the administration of Norco.

Respondent argued that the evidence does not support Staff's requested change to FOF No. 24 and that the proposed finding essentially repeats the wording of the order. Respondent asserts that Staff seeks to add its witness's interpretation of the order to the FOF.

The ALJ declines to make the requested change. As pointed out by Respondent, proposed FOF No. 24 re-states the physician's shorthand notations in his order.¹ Therefore, the proposed finding reflects the documentary evidence in the evidentiary record, and the ALJ recommends that the Board overrule this exception.

2. Staff Exception II.

Staff excepts to proposed FOF Nos. 29, 30, and 32, which state that Respondent administered Morphine to Patient 765346 pursuant to the physician's orders. Staff cites to Respondent's testimony regarding her lack of memory of the event and her interpretation of the order and argues that there is no documentary evidence to support Respondent's actions. According to Staff, Respondent was confused about the provisions of the order and wrongly claimed that it was her judgment call on whether to administer either Norco or Morphine. Further, Staff relies on Respondent's admission in her disclosures that the assessment of pain and choice of medication is subjective and is subject to nursing judgment.

According to Respondent, Staff is arguing that Respondent did not have the authority to administer the Morphine unless she had given the Norco first. In addition, Respondent asserts that the issue is not whether Respondent could exercise her nursing judgment in administering Morphine, but whether she properly followed a physician's order, as found in the FOFs.

The ALJ recommends that the Board overrule Staff's exceptions to proposed FOF Nos. 29, 30, and 32. In the PFD, the ALJ listed the documentary evidence in a timeline that, in her opinion, supports Respondent's position that she was in fact authorized by the physician to administer Morphine to this patient.² Although Staff makes numerous citations to the record, Staff's exceptions do not acknowledge the undisputed evidence that it would have been inappropriate to give Norco orally to this patient because of his lack of bowel sounds. The record shows that on May 5, 2011, this patient was nauseated before he received the Morphine³.

¹ Staff Ex. 13 at 523.

² PFD at 13-14.

³ Staff Ex. 13 at 524.

and had negative bowel sounds at 1930 hours.⁴ Staff's witness testified that a lack of bowel sounds indicates that the intestines were "asleep" and were "not gurgling." She also agreed that many medications are absorbed in the intestines. This is consistent with Respondent's testimony that it would have been detrimental to the patient for him to receive oral medication given his negative bowel sounds, and she would have communicated this information to the physician.⁵ The timing of the telephone order for nausea medication also supports Respondent's testimony that she would have told the physician about the patient's condition and received authorization to give Morphine in this situation.

It is the ALJ's opinion that the preponderance of the evidence shows that Respondent was authorized by a physician to give Morphine to this patient. Because proposed FOF Nos. 29, 30, and 32 support this finding, the ALJ recommends that the Board overrule Staff's exceptions on this issue.

3. Staff Exception III.

Staff excepts to proposed FOF Nos. 38, 39, and 40. Staff disagrees with the ALJ's belief that Respondent testified truthfully. However, as explained in the PFD, it is the ALJ's opinion that Respondent testified credibly, and the ALJ declines to change the proposed findings based on Staff's assessment of the evidence.

Staff alternatively requests an additional finding of fact that Respondent did not document the patient's oxygen saturation levels before and after she administered oxygen to the patient. Respondent counters that such a finding would ignore the evidence of her documenting such oxygen levels at other times.

⁴ Staff Ex. 13 at 580.

⁵ Staff asserts that Respondent's lack of memory of actually consulting with the physician is one reason to discount her version of events. However, in the ALJ's opinion, the fact that Respondent could not recall the specifics of one phone call with one physician involving the administration of medication to one patient over 2 years ago does not impair her credibility as a witness. When viewed in its entirety, the record supports Respondent's version of events, and the ALJ found accordingly.

It is undisputed that the patient's oxygen saturation levels immediately before and after Respondent administered oxygen do not appear in the record. However, as pointed out by Respondent, she did in fact document oxygen saturation at least three times that shift. Accordingly, the ALJ adds an additional finding of fact on this issue:

FOF No. 40a. On June 3, 2011, Respondent documented Patient 76937's oxygen saturation levels at 1600, 2000, and 2400 hours. Respondent did not document Patient's 76937's oxygen saturation levels immediately before and after she administered oxygen to Patient 76937 at 2300 hours on June 3, 2011.

4. Staff Exception IV.

Staff excepted to proposed conclusion of law (COL) No. 8, arguing that the ALJ should split the COL into two COLs, as well as add citations to Texas Occupations Code § 301.452(b)(10) and (b)(13), and other Board rules. As recognized in proposed COL Nos. 1 and 4, section 301.452(b) of the Texas Occupations Code grants the Board the authority to subject a person to disciplinary action for various actions, including a violation of chapter 301 or a Board rule. Therefore, the ALJ declines to add a reference to the Board's enabling statute in COL No. 8.

As shown by the ALJ's reasoning in the PFD, Staff proved that Respondent failed to accurately and completely document the status of various patients. Accordingly, the ALJ included a COL that Respondent violated section 217.11(1)(D) of the Board's rules. However, as the ALJ explained in the PFD, the evidentiary record does not support the elevation of Respondent's conduct to the level of unprofessional conduct or the violation of other minimum standards. Because Staff exceptions do not convince the ALJ that other violations should be cited in COL No. 8, the ALJ recommends that the Board overrule this exception.

5. Staff Exception V.

Staff excepts to COL No. 9, which concludes that Respondent violated 22 Texas Administrative Code § 217.11(1)(D) by failing to accurately and completely document the

Tramadol given to Patient 765567. Respondent contends that this exception should be denied for the same reasons as Exception IV should be denied.

As explained in response to Staff Exception IV., the ALJ set out her reasoning in the PFD that the evidence showed a violation of 22 Texas Administrative Code § 217.11(1)(B), but not the other violations alleged by Staff. Therefore, the ALJ declines to change COL No. 9 as urged by Staff and recommends that the Board overrule this exception.

6. Staff Exception No. VI.

Staff excepts to the absence of COL relating to the Norco allegation discussed above. The ALJ declines to add a COL as requested by Staff because the ALJ disagrees with Staff's assessment of the evidence on this issue.

7. Staff Exception VII.

Staff excepts to the absence of a COL regarding Patient 769379 and the administration of oxygen. As discussed above, the ALJ found Respondent's testimony about consulting with a physician to be credible, and the ALJ declines to find a violation of any statutory or regulatory provision. Furthermore, although Respondent did not document the oxygen saturation levels immediately before and after the administration of oxygen to this patient, in light of the evidentiary entire record, the ALJ concludes that a violation did not occur as alleged by Staff. Respondent documented her neurological assessment of the patient both before and after the administration of oxygen at 1950 and 2300 hours on June 3, 2011,⁶ she documented the patient's oxygen saturation levels on 1600, 2000, and 2400 hours on that same date,⁷ and she consulted with the family and the physician regarding the patient's status. The evidentiary record shows that Respondent sought out the physician and explained the patient's status. In the ALJ's opinion, Respondent did not violate the provisions of the Texas Occupations Code or the rules of the Board. Accordingly, the ALJ recommends that the Board overrule Staff's Exception VII.

⁶ Staff Ex. 13 at 690

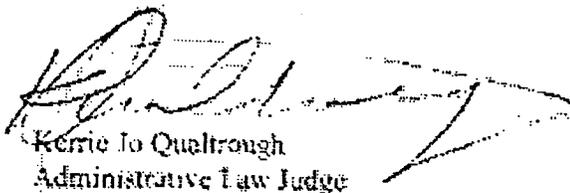
⁷ Staff Ex 13 at 673.

8. Staff Exception No. VIII.

Staff excepts to the ALJ's recommended sanction because it did not comply with the sanction recommended by its witness. Respondent also requests a change to the ALJ's recommendation based on past Board practice.

The ALJ declines to make the changes requested by the parties. The ALJ has not changed her proposed findings of fact and conclusions of law in response to Staff's exceptions in a manner that warrants a change in the ALJ's sanction recommendation. In addition, there is very little, if any, evidence in the record regarding past Board practice. The Board is the ultimate decision-maker regarding a sanction and is free to accept or reject the ALJ's recommendation.⁸ For these reasons, the ALJ declines to amend her sanction recommendation.

Sincerely,


Kerrie Jo Qualtrough
Administrative Law Judge

KJQ/vg

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⁸ *Granek v. Texas State Bd. of Med. Examiners*, 172 S.W.2d 761, 781 (Tex. App.—Austin 2005, no pet.).