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Patricia A. Plummer
Executive Director of the Board

DOCKET NUMBER 507-14-2038

**IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBERS 651563 & 163220 ,
ISSUED TO
ANGELA L. TROTTER**

**§ BEFORE THE STATE OFFICE
§ OF
§ ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

**TO: ANGELA L. TROTTER
c/o MARC MEYER, ATTORNEY
LAW OFFICE OF MARC MEYER, PLLC
33300 EGYPT LANE, SUITE B200
MAGNOLIA, TX 77354**

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

At the regularly scheduled public meeting on October 23-24, 2014, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Respondent's exceptions to the PFD; (3) Staff's response to Respondent's exceptions to the PFD; (4) Respondent's reply to Staff's response to Respondent's exceptions to the PFD; (5) the final ALJ letter ruling of September 10, 2014; (6) Staff's recommendation that the Board adopt the PFD with changes; and (7) 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. Respondent filed exceptions to the PFD on September 2, 2014. Staff filed a response to Respondent's exceptions to the PFD on September 4, 2014. On September 8, 2014, Respondent filed a reply to Staff's response to Respondent's exceptions to the PFD. On September 10, 2014, the ALJ issued her final letter decision, in which she declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; Respondent's reply to Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling of September 10, 2014; 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. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

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 generally agrees with the ALJ's recommendation that the Respondent's licenses should be subject to a Probated Suspension². Consistent with the sanction of a Probated Suspension³ under the Board's rules, however, the Board finds that it is appropriate to impose probationary conditions for a period of two years to accompany the sanction.

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 3, 5, and 6 and Conclusions of Law Numbers 8, 10, and 12 raises concerns about the Respondent's ability to safely practice nursing. First, the Board notes that the Respondent has been previously disciplined for related conduct. In 2010, the Respondent received an agreed order for miscalculating an intravenous heparin dose and infusion rate that resulted in the administration of a heparin overdose to a patient⁴. The Respondent received the sanction of a Reprimand with Stipulations⁵. However, despite this prior order, it does not appear that the Respondent has satisfactorily remediated her deficiency. In this matter, the Respondent's failure to correctly set the rate for an insulin infusion posed a serious risk of harm to the patient⁶, and the patient's glucose level did in fact decrease to a point that an additional physician's order was required to stabilize it⁷. Further, the Respondent's behavior encompasses more than one violation of the Nursing Practice Act and Board rules⁸. In addition to incorrectly programming the insulin infusion, the Respondent failed

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 See pages 17 and 19 of the PFD.

³ See 22 Tex. Admin. Code §213.33(e)(6).

⁴ See adopted Finding of Fact Number 6 of the PFD.

⁵ *Id.*

⁶ See pages 11-13 of the PFD.

⁷ See pages 11 and 15 of the PFD.

⁸ The Respondent is subject to discipline for more than one violation of the Nursing Practice Act and Board rules. See pages 5 and 14-16 of the PFD and adopted Conclusions of Law Numbers 8, 10, and 12.

to properly document a patient's blood sugar levels as ordered by the physician⁹. The Board remains cognizant that it must consider taking a more severe disciplinary action if an individual has been previously 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 or is being disciplined for a single violation¹⁰.

The Board recognizes that the Respondent provided some evidence of mitigation at hearing. Two former co-workers who worked with the Respondent at other facilities testified to Respondent's past nursing competency¹¹.

The Board has reviewed and considered the aggravating and mitigating factors in this case and has determined, pursuant to the Board's Disciplinary Matrix, and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e) and (f), that the mitigation in this matter does not outweigh the aggravating factors or the seriousness of the Respondent's conduct. This is particularly true given the vulnerable state of the patients Respondent was caring for, and the fact that the Respondent has been previously disciplined by the Board. The Board therefore finds that the Respondent's conduct collectively warrants a second tier, sanction level II sanction for her violations of the Occupations Code §301.452(b)(1) and(13). Further, based upon its consideration of the aggravating and mitigating factors, the Board finds that the Respondent's licenses should receive the sanction of a Probated Suspension, subject to the probationary conditions set out below.

IT IS THEREFORE ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 651563, and Vocational Nurse License Number 163220, previously issued to ANGELA L. TROTTER, to practice nursing in Texas are hereby SUSPENDED for a period of two (2) years, with the suspension STAYED and Respondent is hereby placed on PROBATION for two (2) years, with the following terms of probation:

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) are encumbered by this Order, the 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

⁹ See page 5 of the PFD and adopted Finding of Fact Number 3 of the PFD.

¹⁰ Occupations Code §301.4531 and 22 Tex. Admin. Code §213.33(b).

¹¹ See page 14 of the PFD.

work.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. 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>.*

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 PROBATION CONDITIONS FOR TWO (2) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

(5) 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.

(6) 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.

(7) 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.

(8) 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) years of employment as a nurse.

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

IT IS FURTHER 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 23rd day of October, 2014.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-14-2038 (August 13, 2014).

SOAH DOCKET NO. 507-14-2038

IN THE MATTER OF THE § BEFORE THE STATE OFFICE
REGISTERED NURSE LICENSE §
NO. 651563 & VOCATIONAL NURSE § OF
LICENSE NO. 163220 ISSUED TO §
ANGELA TROTTER § ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Board) seeks to take disciplinary action against the licenses of Angela Trotter (Respondent) for three alleged violations involving the administration of insulin to a patient. After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds that Staff met its burden of proof on two of the three charges and recommends that the Board suspend Respondent's licenses but probate that suspension, as recommended by Staff.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Matters concerning notice and jurisdiction are 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 June 16, 2014, at the State Office of Administrative Hearings in Austin, Texas. General Counsel James W. Johnston represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on June 16, 2014.

II. APPLICABLE LAW

Chapter 301 of the Texas Occupations Code and the Board's rules govern the practice of nursing in Texas. Under chapter 301, a person is subject to disciplinary action for unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public.¹ Under the Board's rules, "unprofessional conduct" includes:

¹ Tex. Occ. Code § 301.452(b)(10).

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice;² and
- Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.³

In addition, a nurse is also subject to disciplinary action if the nurse fails 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 a risk of harm.⁴ The following Board's rules establish the minimum acceptable standards of nursing practice that every nurse must meet that are relevant to this proceeding:

- Know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;⁵
- Implement measures to promote a safe environment for clients and others;⁶
- Know the rationale for and the effects of medications and treatments and shall correctly administer the same;⁷ and
- Accurately and completely report and document:
 - (i) the client's status including signs and symptoms;
 - (ii) nursing care rendered;
 - (iii) physician, dentist or podiatrist orders;
 - (iv) administration of medications and treatments;
 - (v) client responses; and
 - (vi) contacts with other health care team members concerning significant events regarding client's status.⁸

² 22 Tex. Admin. Code § 217.12(1)(A).

³ 22 Tex. Admin. Code § 217.12(4).

⁴ Tex. Occ. Code § 301.452(b)(13).

⁵ 22 Tex. Admin. Code § 217.11(1)(A).

⁶ 22 Tex. Admin. Code § 217.11(1)(B).

⁷ 22 Tex. Admin. Code § 217.11(1)(C).

⁸ 22 Tex. Admin. Code § 217.11(1)(D).

III. DISCUSSION

A. Background

This case involves the proper administration of insulin through the use of an insulin pump to a medically-fragile patient in the intensive care unit (ICU) of the University General Hospital in Houston, Texas. This is a complicated process that requires the nurse to titrate, or determine, the concentration of insulin and to properly administer the medication through the use of an infusion pump.

Nurses administered insulin to this patient by attaching a bag of insulin to the pump. The nurse must set the pump to deliver the correct volume⁹ of insulin to the patient at the correct rate.¹⁰ In its First Amended Formal Charges, Staff alleged that Respondent administered insulin that exceeded the physician's order for three hours and set the pump to administer an exceedingly high dose of insulin. Staff also alleged that Respondent failed to document the patient's blood sugar levels.¹¹

Danielle Greene testified on behalf of Staff. Ms. Greene is a Board investigator and has been a licensed registered nurse since February 2011. Respondent challenged Ms. Greene's status as an expert witness and demonstrated that Ms. Greene had never worked in an ICU or an emergency room, had never started an insulin drip, and had never titrated insulin for a patient outside of nursing school. Staff responded that Ms. Greene is an expert because she is a registered nurse and she would testify about her review of the patient's medical records. Although the ALJ recognized that Ms. Greene had limited expertise in this area, the ALJ allowed Ms. Greene to testify as an expert witness, and the ALJ will give her testimony and opinions the appropriate weight.

⁹ Volume is measured in "ccs," "mls," or "units," and these three measurements are equivalent.

¹⁰ The rate at which insulin is administered is expressed in units/kilogram (kg)/hour. The volume of kilograms in the calculation is the patient's weight.

¹¹ Throughout the hearing, the parties used the terms "serum glucose" and "blood sugar" interchangeably.

Respondent also has a previous Board order. On August 17, 2010, the Board entered an agreed order finding that on December 5, 2008, Respondent had miscalculated an intravenous heparin dose and infusion rate that resulted in a heparin overdose.¹²

B. Charge I

1. Staff's Allegations and Evidence

Staff alleged in its First Amended Formal Charges that on August 26, 2012, Respondent failed to document the patient's blood sugar level at 1300 hours as required.¹³ According to Staff, Respondent's conduct resulted in an incomplete medical record. Therefore, Staff asserts Respondent violated 22 Texas Administrative Code § 217.11(1)(A), (1)(B), and (1)(D), and her conduct resulted in unprofessional conduct under section 217.12(1)(A) and (4).

Ms. Greene testified that the patient's Critical Care Flow Sheet (Flow Sheet) for August 26, 2012, shows that Respondent did not document the patient's blood sugar level at 1300 hours.¹⁴ Respondent was required to record these levels every two hours; however, the boxes on the Flow Sheet for 1300 and 1400 hours are blank. Ms. Greene opined that by failing to record this information, Respondent deprived subsequent caregivers of essential information for a medically-fragile patient with uncontrolled diabetes.

2. Respondent's Evidence

Respondent testified that she did in fact take the required readings of the patient's blood sugar levels. According to Respondent, a nurse may test for these levels at any time during the hour. She testified that she took the patient's blood sugar level, as indicated in the 1200 hours box,¹⁵ right before 1300 hours. Although she wrote the level in the box under 1200 hours, she

¹² Staff Ex. 3a at 7.

¹³ Staff Ex. 3a at 3.

¹⁴ Staff Ex. 6 at 81.

¹⁵ The record shows that the patient's blood sugar level during the 1200 hours period was 165 milligrams (mg)/deciliters (dL). Staff Ex. 6 at 81.

did in fact take the blood sugar level every two hours and recorded it properly on the patient's records. In addition, the patient's bag of insulin ran out at 1200 hours, and she had to wait several hours for a replacement.

3. ALJ's Analysis

The ALJ concludes that Respondent failed to properly document this patient's blood sugar level at 1300 or 1400 hours on August 26, 2012. The physician's order required a nurse to monitor the patient's serum glucose level every two hours.¹⁶ Assuming a nurse may actually measure a patient's blood sugar at any time during the hour, the patient's Flow Sheet does not indicate the Respondent monitored the patient's blood sugar level at 1300 hours or at 1400 hours.¹⁷ Therefore, regardless of when Respondent actually took the measurement during the hour, the Flow Sheet does not indicate that she tested the patient's blood sugar level every two hours as required. Therefore, the ALJ concludes that Respondent violated 22 Texas Administrative Code § 217.11(1)(A) and (1)(D). However, in the ALJ's opinion, the evidence does not support a finding that Respondent failed to implement measures to promote a safe environment as required by section 217.11(1)(B) or that her actions rose to the level of unprofessional conduct under section 217.12.

C. Charge II

1. Staff's Allegations and Evidence

Staff alleged that on August 26, 2012, Respondent inappropriately administered 11 units of insulin per hour for three hours, which is in excess of the prescribed amount. According to Staff, this conduct could have caused injury to the patient and violated the minimum standards in 22 Texas Administrative Code § 217.11(1)(A), (1)(B), and (1)(C). Staff also asserted that her actions resulted in unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(A) and (4).

¹⁶ Staff Ex. 6 at 46.

¹⁷ Staff Ex. 6 at 81.

Ms. Greene testified that Respondent inappropriately administered 11 units of insulin per hour for three hours. As shown by the Flow Sheet, Respondent indicated that 11 units per hour were infused for 1500, 1600, and 1700 hours.¹⁸ Ms. Greene asserted that this violated the physician's order, which reads "[w]hen serum glucose is 300-250 milligrams (mg)/deciliters (dL), decrease rate of infusion to 0.05 (0.05-0.1) units/kilogram (kg)/hour."¹⁹ According to Ms. Greene, the patient's blood sugar level was 253 mg/dL at 1500 hours, and the patient's weight was 55.3 kilograms.²⁰ Therefore, the appropriate calculation for the rate of infusion is 0.05 multiplied by 55.3, which equals 2.75 units/hour. In Ms. Greene's opinion, when Respondent gave the patient 11 units per hour instead of 2.75, she exceeded the amount authorized by the physician's order. However, Ms. Greene admitted that the order does not specify how to titrate insulin, and she could not testify as to how titration is done.

Ms. Greene further testified about the effects of too much insulin. An overdose of insulin could cause hypoglycemia, or the lowering of the patient's blood sugar, which in turn could cause seizures and death.

2. Respondent's Evidence

Respondent explained that the physician's order in the record was a telephone order that she took over the phone, as she indicated in her notes of August 25, 2012.²¹ After taking the telephone order, Respondent had difficulty locating the hospital's standard order form for the administration of insulin. Once she located the proper form and filled it out, she realized she was missing information because the physician's original telephone order only addressed the situation in which the patient's blood sugar level was decreasing. In order to determine what to do if the patient's blood sugar level was increasing, she called the physician back and got additional instructions but did not document those new instructions. She testified that she

¹⁸ Staff Ex. 6 at 83.

¹⁹ Staff Ex. 6 at 46.

²⁰ Ms. Greene testified that the patient's weight was 55.3 kilograms. However, the patient's Flow Show indicates that the patient's "previous weight" was 55.3 kilograms but "today's weight" (August 26, 2012) was 62 kilograms. Staff Ex. 6 at 83.

²¹ Staff Ex. 6 at 44.

infused the 11 units of insulin per hour pursuant to that second conversation she had with the physician. The physician subsequently came to the hospital, made changes to the telephone order, and signed the order that is in the record.²² However, the changes made by the physician did not reflect his instructions to Respondent about increasing blood sugar levels.

The Flow Sheet shows that the patient's bag of insulin ran out at 1200 hours, and the patient did not receive additional insulin until 1500 hours.²³ As a result, his blood sugar level rose from 165 mg/dL at 1200 hours to 253 mg/dL at 1500 hours.²⁴ Respondent testified that when the patient's blood sugar level increased to 253 mg/dL, she titrated the insulin to a rate of 0.2 units/kg/hour to comply with the directive to "[t]itrate to a serum glucose level of < 150."²⁵

According to Respondent, 11 units of insulin translate to a rate of 0.2 units/kg/hour, and the physician's original telephone order justified the 11 units of insulin for this patient because the order does not contain an upper limit on the volume of insulin. However, she subsequently stated that the order "on its face" did not authorize 11 units. Respondent also asserts that there is a conflict in the physician's order. As previously stated, the order requires the titration of insulin "to a serum glucose level of < 150."²⁶ Respondent maintains that this provision conflicts with the next provision, which states: "When serum glucose is 300-250 milligrams/dL, decrease rate of infusion to 0.05 (0.05-0.1) units/kg/hour."²⁷

²² Staff Ex. 6 at 46.

²³ Staff Ex. 6 at 82.

²⁴ Staff Ex. 6 at 81-82.

²⁵ Staff Ex. 6 at 46. Pursuant to the physician's telephone order, Respondent wrote in "< 150" into the blank on the hospital's form.

²⁶ Staff Ex. 6 at 46.

²⁷ Pursuant to the physician's telephone order, Respondent wrote in "0.05" into the blank on the hospital's order form. Staff Ex. 6 at 46.

3. ALJ's Analysis

The ALJ concludes that Staff did not meet its burden of proof on Charge II. The evidence on this charge is unclear and contradictory. Ms. Greene testified that Respondent incorrectly administered 11 units to the patient in violation of the physician's order.²⁸ According to Ms. Greene, this volume equates to a rate of 0.2 units/kg/hour, based on the patient's weight of 55 kilograms.²⁹ She stated that Respondent violated the rate in the physician's order that requires the decrease of the rate of infusion to 0.05 units/kg/hour when the patient's serum glucose is between 250 to 300 mg/dL.

If Ms. Greene's interpretation of the physician's order is correct, when the patient's blood sugar level was between 250 and 300 mg/dL, then the patient could only receive 2.75 units per hour (0.05 times 55.3 kg equals 2.75 units/hour). However, the order also requires the nurse to "[t]itrate to a serum glucose level of < 150." According to Ms. Greene, nurses are required to "titrate" the amount of insulin administered in response to the patient's blood sugar levels. She testified that the term "titration" refers to an ongoing calculation to adjust the rate of infusion based on the patient's response to the medication, as measured by changes in the patient's serum glucose level. If Ms. Greene's opinion of the physician's order is correct regarding the rate, then the amount of insulin would not be adjusted in response to the blood sugar level. Insulin would always be administered at the rate of 0.05 units/kg/hour if the patient's glucose level was between 250 and 300 mg/dL, even though the order also required titration to achieve a serum glucose level of less than 150 mg/dL. This leaves the ALJ with the suspicion that either the physician's order is contradictory, as alleged by Respondent, or something is missing from Ms. Greene's analysis. As Ms. Greene admitted, she has no experience calculating, or titrating, the proper amount of insulin to be administered to a patient, and the physician's order does not state how to titrate insulin for this patient. Given the apparent contradiction in the order, the ALJ gives little weight to Ms. Greene's opinion that Respondent violated the physician's order.

²⁸ Staff Ex. 6 at 83.

²⁹ Ms. Green's calculation is as follows: 0.2 multiplied by 55 kilograms equals 11 units per hour. As previously stated, the patient's actual weight on the previous day was 55.3 kilograms.

However, Respondent's testimony is contradictory, as well. Staff asked her several times whether the 11 units she administered to the patient were authorized by the physician's order. At one point, she stated that yes, she was following the physician's order. At another point, she stated that the order "on its face" did not authorize the administration of 11 units. She further testified that she was following the physician's undocumented follow-up instructions. However, Respondent also pointed out that the physician's order in the record does not contain an upper limit on the amount of insulin that a nurse can administer to a patient, and the ALJ agrees with her assessment.³⁰ Furthermore, Respondent opined that there is a conflict between the directive to titrate to a serum glucose level of less than 150 mg/dL and the directive to decrease the rate of infusion to 0.05 units/kg/hour when the patient's serum glucose level is between 250 and 300 mg/dL. Respondent's testimony rings true to the ALJ given Respondent's experience in the ICU and from what the ALJ can discern from the physician's order and the other evidence.

The ALJ acknowledges that Respondent's answers to certain questions appear to be admissions of a violation. However, as stated on the record, the ALJ was concerned that the parties were using terms differently and that the record was becoming confused. For example, at one point during Staff's questioning of Respondent, Staff and Respondent were discussing the "parameters" in the physician's order, but it became clear from the discussion that that term meant something different to Staff than it did to Respondent. Given this lack of clarity and confusion, the ALJ is unable to conclude that Respondent admitted she violated the physician's order by administering 11 units of insulin per hour to this patient.

In sum, the ALJ finds that Staff failed to prove by a preponderance of the evidence that Respondent violated the physician's order by administering to this patient 11 units of insulin per hour for three hours on August 26, 2012. Respondent credibly testified that the physician's order does not contain an upper limit on the amount of insulin that could have been administered to the patient. In addition, the evidence in the record indicates that the physician's order may contain contradictory provisions. For the reasons stated in this proposal for decision, the ALJ does not recommend any findings that Respondent committed the violation as alleged in Charge II.

³⁰ Staff asserted that the following provision in the order established a cap on the rate of infusion: "Start infusion at 0.1 units/kg/hour." Staff Ex. 6 at 46. The ALJ agrees with Respondent that this is the starting point for the infusion of insulin, not a cap on the rate at which insulin could be infused.

D. Charge III**1. Staff's Allegation and Evidence**

Staff alleged in its First Amended Formal Charges that on August 26, 2012, Respondent incorrectly set the rate for an insulin drip to administer insulin at 1.5 units/kg/hour, instead of the prescribed rate of 0.5 units/kg/hour.³¹ According to Staff, Respondent's conduct could have "resulted in the patient receiving 82.5 units of insulin in an hour, which exposed the patient to symptoms of hypoglycemia, including fever, chills and coma."³² The Staff contends that Respondent's conduct constitutes grounds for disciplinary action because she violated the nursing practice standards in 22 Texas Administrative Code § 217.11(1)(A), (1)(B) and (1)(C) and her actions constituted unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(A) and (4).

Ms. Greene testified that at 1800 hours, the patient's Flow Sheet reflects that he was receiving insulin at a rate of 1.5 units/kg/hour.³³ According to Ms. Greene, this equates to a volume of 82.5 units of insulin per hour, and this amount of insulin was too much and could have led to the patient's death. Ms. Greene testified that in her opinion, Respondent incorrectly set the rate on the pump.

Vilma Saldivar Bilogan also testified at the hearing. She was the nurse on duty who cared for this patient in the ICU during the shifts immediately before and after Respondent's shift on August 26, 2012.³⁴ She testified that during the shift report, she noticed that the patient's pump was set to infuse 82.5 units of insulin per hour. She knew that was too high and was more insulin that the patient should have received. Ms. Bilogan stated that she turned the pump off,

³¹ Staff Ex. 3 at 3.

³² Staff Ex. 3 at 3.

³³ Staff Ex. 6 at 82.

³⁴ The nurses work on 12-hour shifts. On August 25, 2012, Ms. Bilogan worked the night shift from 1900 to 0700 hours. Respondent's day shift began at 0700 hours and ended at 1900 hours on August 26, 2012, when Ms. Bilogan returned for her next shift.

took the patient's blood sugar, and contacted the charge nurse.³⁵ Ms. Bilogan then monitored the patient's blood sugar levels every 30 minutes. For three hours, the patient's blood sugar levels decreased, and Ms. Bilogan then called the physician with this information.

Michelle Rumpf, the charge nurse on duty on August 26, 2012, testified that Ms. Bilogan informed her at the beginning of the shift about the incorrect pump setting. When Ms. Rumpf came into the patient's room, the pump was off. When a pump is restarted, it will indicate the previous settings. According to Ms. Rumpf, when Ms. Bilogan turned the pump back on, the pump indicated that it was previously set to infuse 82.5 units of insulin per hour. However, the pump did not indicate when someone set it to administer 82.5 units per hour or how long it had been infusing insulin at that setting.

In response to the pump setting, Ms. Rumpf ordered Ms. Bilogan to check the patient's blood sugar level every 30 minutes. After three hours, the blood sugar level dropped to 50 mg/dL, and the nursing staff called the physician. In response, the physician prescribed "D50 and D10" to counteract the excess insulin.

Ms. Rumpf testified that a nurse would have had to determine how to set the pump based on the patient's weight because the pump is not typically set using a weight-based calculation. She stated that the hospital does not usually run insulin based on the weight of the patient, but on the blood sugar level. In addition, Ms. Rumpf could not recall if the pump was a rental pump or a pump owned by the hospital.

Robert Thomas was the house supervisor³⁶ on August 26, 2012. He testified that the patient's records indicate that the pump was turned off at 1925 hours, and he estimates that after he was informed of the problem around 1930 hours, he went to the patient's room with Ms. Bilogan and Ms. Rumpf.³⁷ He also observed that the pump had been previously set at 82.5 units per hour. He testified that this was an extremely high volume of insulin, and the dose

³⁵ In Staff's rebuttal case, Ms. Bilogan testified that Respondent told her not to touch the pump, and she did not.

³⁶ Mr. Thomas testified he has been an registered nurse since 1978.

³⁷ Ms. Bilogan's nurses notes indicate that she notified Mr. Thomas at 2225 hours. Staff Ex. 6 at 85.

was higher than it should have been. He stated that the rate should have been set at 0.1 unit/kg/hour, based on the blood sugar level,³⁸ and the dose the physician prescribed is a very low dose.

Mr. Thomas explained that insulin comes in a 100-unit bag. At the amount the pump was set to administer, the patient could have received almost the entire bag in one hour. If a patient received that much insulin, there would be a rapid decline in the patient's blood sugar level because of the high dose, according to Mr. Thomas.

Mr. Thomas also discussed how pumps are set to infuse the proper dosage of insulin. Typically, a nurse will have to enter the patient's weight into the pump to set the dosage based on the rate expressed in units/kg/hour. In order to set the pump to deliver a dosage based on the volume of insulin infused, i.e. units per hour, a nurse would have to override the pump. Pumps are preprogrammed with "guardrails," and these guardrails ask for the volume and rate. To set a pump to administer 82.5 units/hour, a nurse would have had to override the guardrails. Mr. Thomas also could not recall if the pump at issue here was a rental pump.

2. Respondent's Evidence

As previously stated, Ms. Bilogan worked the shift immediately before and after Respondent's August 26, 2012 shift at issue in this proceeding. Respondent testified that when she arrived to begin her shift after Ms. Bilogan's first shift, she noted that the insulin pump was set in a different mode and not the correct mode of units/kg/hour. Therefore, she had to reset the pump because it was programmed incorrectly, presumably by Ms. Bilogan. At 0740 hours on August 26, 2012, Respondent wrote in her nurses notes: "insulin pump changed to previous setting of unit/kg/hour by this nurse."³⁹

Respondent testified that at the end of her shift, she was on the telephone with another physician on an unrelated matter, and Ms. Bilogan was in the patient's room before she should

³⁸ This conflicts with Ms. Greene's testimony that the rate should have been set at 0.05 units/kg/hour.

³⁹ Staff Ex. 6 at 80.

have been. Ms. Bilogan then came to Respondent and told her that the patient's pump was set at a rate of 1.5 units/kg/hour. In response to Ms. Bilogan's statement, Respondent wrote down 1.5 on the patient's chart for the rate at 1800 hours,⁴⁰ but she did not independently verify that amount.⁴¹ Respondent testified that when Ms. Bilogan said that the patient was receiving 82.5 units per hour, Respondent then realized that something was very wrong. Respondent testified that she went to check the pump, but Ms. Bilogan told her that she would fix it. Respondent then checked the patient's blood sugar level, saw that it was at 146 mg/dL, and recorded that level on the Flow Sheet.⁴²

Although Respondent conceded that 82.5 units was a very high dose, she maintained that she did not set the pump to deliver such a high volume of insulin. She stated that since her prior board order, she has been very conscientious in setting the pumps, and has had other nurses check her calculations. She pointed out that a review of the Flow Sheet shows that she had not set a rate that high throughout the entire night.⁴³ Further, she would not have changed the setting on the pump between 1700 to 1800 hours because a change was not necessitated by the patient's blood sugar levels.⁴⁴

At the time of the incident, Respondent did not document what had occurred regarding the pump, even though this was a significant event in the care of this patient. However, Respondent did request to amend the record at the "root and cause analysis meeting" to reflect what had happened, but the hospital denied this request. She also requested that the pump's "electronic brain" be downloaded so that it could be determined when and how long the pump was set to deliver 82.5 units of insulin per hour. However, the hospital told Respondent that the rental pump had been sent back and denied Respondent's request. Respondent further testified about the guardrails on the pump. She stated that to set the rate at such a high level would require overriding the critical-care guardrails, and that she had never taken that step.

⁴⁰ Staff Ex. 6 at 82.

⁴¹ The Flow Sheet indicates that the rate for 1700 hours 0.2 units/kg/hour, as compared to 1.5 units/kg/hour for 1800 hours. Staff Ex. 6 at 82.

⁴² Staff Ex. 6 at 82.

⁴³ Staff Ex. 6 at 81-82.

⁴⁴ The patient's blood sugar level was 183 mg/dL at 1700 hours. Staff Ex. 6 at 82.

Respondent also presented the testimony of Celeste Bahar and David Jacobs, two individuals who had previously worked with Respondent. Ms. Bahar had worked in the ICU with Respondent at another hospital. She was impressed with Respondent's excellent nursing skills and knew about her prior board order. Ms. Bahar testified that Respondent was very careful and double-checked her medications, even getting other nurses to verify that the doses were proper. Mr. Jacob worked with Respondent at long-term care facility. He also testified that Respondent had excellent nursing skills and spoke about one incident in which Respondent saved a patient.

3. ALJ's Analysis

It is undisputed that the pump was set to administer 82.5 units/hour of insulin to the patient, and this amount is an exceedingly high volume not authorized by the physician. What is not resolved by the evidence is who set the pump to administer such a high volume and how long this amount of insulin was administered to the patient. Respondent credibly testified that she would have had to override the pump's preprogrammed settings to administer such a high dosage of insulin. She further testified that she had no reason to alter the settings, and this testimony is supported by the Flow Sheet.⁴⁵ Except for 1800 hours, she administered insulin at much lower rates throughout her entire shift, as shown below:

Hours	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800
Glucose Level ⁴⁶	166	180	174	166	165			253		183	146
Rate of Insulin ⁴⁷	0.09	0.11	0.15	0.15				11 ⁴⁸		0.2	1.5

The Flow Sheet does not indicate a change in blood sugar levels that would have necessitated such a change in the rate between 1600 and 1800 hours. She further testified that

⁴⁵ Staff Ex. 6 at 81-82.

⁴⁶ Glucose level is measured in mg/dL.

⁴⁷ These rates are expressed in units/kg/hour.

⁴⁸ This appears to be volume of insulin given and not the rate the medication was administered. See, Staff Ex. 6 at 83.

for 1800 hours, she indicated a rate of 1.5 units/kg/hour because that is what Ms. Bilogan told her was the setting on the pump. Respondent also stated that she wrote in the blood sugar level of 146 mg/dL at 1800 hours when she measured the level in response to Ms. Bilogan's statements regarding the pump setting.

Respondent also raised concerns that maybe Ms. Bilogan altered the setting on the pump. As Respondent testified, when she arrived for her shift on August 26, 2012, the settings on the pump were incorrect, and Ms. Bilogan was the nurse who would have set the pump incorrectly. Respondent further testified that at the end of Respondent's shift, Ms. Bilogan entered the patient's room without Respondent, and this was not the proper procedure. This raises a question of whether Ms. Bilogan may have altered the setting on the pump at that time.

However, what the evidence does show is that after 1800 hours, the patient's blood sugar levels declined precipitously, as shown by the Flow Sheet:⁴⁹

Hours	1700	1800	1925	1957	2019	2051	2100	2200	2300
Glucose Level ⁵⁰	183	146	118	97	86	72	63	56	132

At 2230 hours, the nursing staff administered the D50 as ordered by the physician to counteract the insulin, and his blood sugar began to rise, as indicated by the glucose level at 2300 hours. This indicates to the ALJ that the patient may have received the higher dosage for a longer period of time than had Ms. Bilogan changed the setting on the pump at the beginning of her shift at 1900 hours.

Although there is evidence tending to show that Respondent did not set the pump to administer 82.5 units of insulin per hour, she was the nurse who had the responsibility to care for the patient during her shift. In the absence of evidence showing that someone else actually tampered with the pump, the ALJ can only conclude that Respondent improperly administered the large dose of insulin to this patient. Respondent indicated on the Flow Sheet that the patient received insulin at the rate of 1.5 unit/kg/hour, which translates to a volume of 82.5 units per

⁴⁹ Staff Ex. 6 at 82.

⁵⁰ Glucose level is measured in mg/dL.

hour. The ALJ recognizes that Respondent attempted to amend her nurse's notes on the patient's chart after the incident to reflect her account of what had happened but the hospital would not allow her to make such an amendment. Nevertheless, she alone had the responsibility to properly indicate on the records the amount and rate of insulin administered to the patient. Also, the patient's serum glucose level dropped quickly after 1800 hours. Therefore, the ALJ concludes that, as shown by the Flow Sheet, Respondent improperly administered insulin at a rate of 1.5 units/kg/hour, which equates to a volume of 82.5 units to the patient.

Based on the preponderance of the evidence, the ALJ recommends that the Board find that Respondent violated 22 Texas Administrative Code § 217.11(1)(C). This standard of care required Respondent to correctly administer the insulin. By failing to conform her conduct to the standard of care in section 217.11(1)(C), Respondent also violated section 217.11(1)(A). The ALJ does not conclude that Respondent failed to implement measures to promote a safe environment as contemplated by section 217.11(1)(B). Further, there is no evidence of such carelessness on the part of Respondent that her conduct constituted unprofessional conduct in violation of section 217.12.

E. 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.⁵¹ According to Texas Occupations Code § 301.4531(c), the Board may take more severe disciplinary action if the nurse is to be disciplined for multiple violations or had prior Board orders.

1. Staff's Position

Staff presented no testimony regarding the appropriate sanction in this case. In its closing arguments, Staff noted that the Board had previously sanctioned Respondent through an August 17, 2010 Agreed Order⁵² and that the Texas Occupations Code § 301.4531(c) authorized

⁵¹ 22 Tex. Admin. Code § 213.33(b).

⁵² Staff Ex. 3a at 6-18.

the Board to take more severe disciplinary action because of the previous order. For Respondent's failure to conform to minimum nursing standards, Staff recommended a Tier 1, Sanction Level 2 sanction. Because Respondent's prior Board order resulted in a reprimand, Staff recommended a probated suspension of Respondent's licenses.

2. Respondent's Position

In her closing arguments, Respondent asserted that Staff had not proved any of the violations. However, Respondent stated that she did not disagree with Staff's sanction recommendation if there was a finding of violation.

3. ALJ's Recommendation

The parties are in apparent agreement with the recommended sanction. Therefore, the ALJ recommends that Respondent's licenses be suspended and that suspension should be probated.

IV. FINDINGS OF FACT

1. Angela L. Trotter (Respondent) is both a registered nurse, license number 651563, and a licensed vocational nurse, license number 163220. Both licenses were issued by the Texas Board of Nursing (Board).
2. Respondent was employed by University General Hospital in Houston, Texas, on August 25 and 26, 2012.
3. On August 26, 2012, Respondent failed to document Patient No. 03-92-15's blood sugar level at 1300 and 1400 hours.
4. The evidence does not show that on August 26, 2012, Respondent inappropriately administered 11 units of insulin per hour for three hours to Patient No. 03-92-15.
5. On August 26, 2012, Respondent incorrectly set the rate for an insulin infusion to administer insulin at 1.5 units/kilogram/hour to Patient No. 03-92-15, which could have resulted in 82.5 units/hour being administered to the patient.
6. On August 17, 2010, the Board entered into an agreed order with Respondent. This agreed order found that Respondent had miscalculated an intravenous heparin dose and

infusion rate that resulted in the administration of a heparin overdose to a patient. Respondent received a reprimand with stipulations as a sanction.

7. On February 14, 2014, Staff mailed to Respondent its Notice of Hearing with the First Amended Formal Charges attached.
8. The notice 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.
9. Administrative Law Judge Kerrie Jo Qualtrough convened the hearing on the merits on June 16, 2014, at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel James W. Johnston represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on June 16, 2016.

V. CONCLUSIONS OF LAW

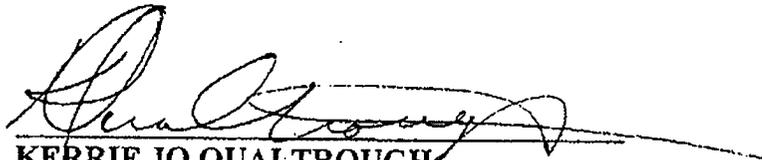
1. The Board has jurisdiction to govern the practice of nursing in Texas. Tex. Occ. Code ch. 301.
2. SOAH has jurisdiction to conduct formal hearings in matters involving alleged violations. Tex. Occ. Code § 301.459(a); Tex. Gov't Code ch. 2003.
3. The notice of the hearing met the requirements of Texas 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 adequately care 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 a patient's status. 22 Tex. Admin. Code § 217.11(1)(D).

8. Respondent failed to accurately and completely document the blood sugar level of Patient No. 03-92-15. 22 Tex. Admin. Code § 217.11(1)(D).
9. The Board's nursing standards require all nurses to know the rationale for and the effects of medications and treatments and to correctly administer the same. 22 Tex. Admin. Code § 217.11(1)(C).
10. Respondent failed to correctly administer insulin to Patient No. 03-92-15. 22 Tex. Admin. Code § 217.11(1)(C).
11. The Board's nursing standards require all nurses to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations. 22 Tex. Admin. Code § 217.11(1)(A).
12. Respondent failed to conform to the Board's rules by failing to accurately and completely document the blood sugar level of Patient No. 03-92-15 and by failing to correctly administer insulin to Patient No. 03-92-15. 22 Tex. Admin. Code § 217.11(1)(A).
13. Staff did not meet its burden of proof that Respondent inappropriately administered 11 units of insulin per hour for three hours on August 26, 2012.

VI. RECOMMENDATION

The ALJ recommends that the Board suspend Respondent's license to practice nursing and that the suspension be probated.

SIGNED August 13, 2014.


KERRIE JO QUALTROUGH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING