State Office of Administrative Hearings

Shelia Bailey Taylor
Chief Administrative Law Judge

October 6, 2000

Katherine A. Thomas, M.N., R.N.
Executive Director
Board of Nurse Examiners for the State of Texas
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

HAND DELIVERY

RE: Docket No. 507-00-1226; In the Matter of Permanent Certificate Number 510065 Issued to Jan E. Brown

Dear Ms. Thomas:

Enclosed please find a Proposal for Decision and a proposed Order of the Board in the above-referenced cause for the consideration of the Board of Nurse Examiners for the State of Texas. Copies of the documents are being sent to James W. Johnston, General Counsel, and to Jan E. Brown, Respondent in this matter. For reasons discussed in the proposal, I have recommended Respondent receive from the Board a one-year reprimand with stipulations.

Pursuant to the Administrative Procedure Act, each party has the right to file exceptions to the proposal, accompanied by supporting briefs. Exceptions, replies to the exceptions, and supporting briefs must be filed with the Board according to the agency's rules, with a copy to the State Office of Administrative Hearings. A party filing exceptions, replies, and briefs must serve a copy on the other party hereto.

Sincerely,

Michael J. Borkland
Administrative Law Judge

MJB/vg
Enclosures

cc: James W. Johnston, General Counsel, Board of Nurse Examiners for the State of Texas - **VIA HAND DELIVERY**
Jan E. Brown, 4206 Elmgrove Crt., Arlington, TX 76015- **VIA REGULAR MAIL**
Rommel Corro, Docket Clerk, State Office of Administrative Hearings - **VIA HAND DELIVERY**

DOCKET NO. 507-00-1226

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

PROPOSAL FOR DECISION

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

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

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

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

II. DISCUSSION

A. Background.

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

B. Formal Charges.

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

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[1]Now within the TEXAS OCCUPATION CODE.

CHARGE I.

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

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

CHARGE II.

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

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

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

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

C. *Legal Standards.*

The Act provided in part at Article 4525:

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

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

Board rules provide:

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

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

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

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

(4) evidence of practice history;

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

(9) the deterrent effect of the penalty imposed.

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

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

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

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

3. 25 TAC § 115.21

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

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

The Code of Federal Regulation (CFR) provides:

1. 42 CFR § 484.36

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

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

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

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

D. Staff's Evidence.

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

1. Karen Burk, RN.

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

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

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

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

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

2. Carla S. Johnston, RN.

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

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

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

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

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

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

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

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

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

3. Tammy Prine, RN.

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

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

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

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

Another Brown County Visiting Nurses, Inc. patient assessed by Ms. Prine was found to be very ill. She contacted the patient's physician, and the patient was admitted to a hospital for treatment. Ms. Prine found no evidence that either an RN or LVN was scheduled to see the patient that day. Also, the patient could not tell Ms. Prine when she last saw a nurse. The patient was not supervised and this contributed to the deterioration of her condition to the point that she had to be hospitalized.

In reviewing agency records, Ms. Prine discovered that orders and plans of care requiring RN signatures were not signed. Ms. Prine stated that this is significant because an RN is required to review and evaluate plans of care to protect the public health.

Ms. Prine also testified that she was present when the LVN stated that she had been authorized to sign the RN's signature to paperwork. The LVN stated that she did it all the time. Ms. Prine was shocked by this statement.

4. Gary Walters, RN.

Mr. Walters has worked for the Board for nine years. In his current position as a senior investigator, he conducts investigations and supervises five other investigators. Mr. Walters graduated from nursing school in 1985.

Mr. Walters is intimately familiar with nursing regulations. He refers to them on a daily basis in conducting investigations, and in discussions with Board members. He has testified for the Board as both a fact and expert witness.

Mr. Walters reviewed the case to determine if regulations had been violated. He concluded that there was evidence of actual or potential harm to patients, lack of truthfulness, and misrepresentation. He stated that all nurses are trained to not delegate their authority to sign medical records. A non-RN is not permitted to sign medical documents with an RN's signature. Mr. Walters testified that allowing an unlicensed person to sign an RN's name to medical records shows a lack of truthfulness and trustworthiness, and is misrepresentation on the part of the RN.

Mr. Walters stated that the appropriate discipline for Respondent is a reprimand with stipulations. He believes that Respondent should be required to take remedial education with courses in nursing jurisprudence, documentation, and ethics. Further, he recommended that Respondent be monitored for one year with quarterly reports sent to the Board. He stated that this would remove Respondent from the home health care area for a year, and she could work in a situation where a nurse would be available for questions.

E. Respondent's Evidence.

Respondent offered no evidence.

III. ANALYSIS AND RECOMMENDATION

The testimony of Karen Burk, Carla Johnston, and Tammy Prine makes it abundantly clear that Respondent failed to adequately care for her patients, and exposed them unnecessarily to risk of harm. Respondent moved 140 miles from the location of her home health care agency, was unable to adequately supervise her patients' care. and failed to provide for an alternate supervisory RN which left important medical decisions in the hands of an LVN. She allowed an LVN and an unlicensed staff member to complete and sign documentation regarding skilled nursing visits. Additionally, Respondent failed to perform and document supervisory aide visits. Her agency provided home nursing services for patients who did not qualify for home health aid. Further, two of Respondent's patients had deteriorating medical conditions that required, but did not receive, medical intervention. Neither of these patients had ever met Respondent. Respondent was an absentee RN and is deserving of a reprimand with stipulations.

IV. PROPOSED FINDINGS OF FACT

1. Jan E. Brown (Respondent) holds a Texas license to practice professional nursing under Permanent Certificate Number 510065.

2. By letter dated July 18, 2000, Staff of the Board of Nurse Examiners (Staff) sent notice to Respondent that a disciplinary hearing had been scheduled in this matter. The notice included a copy of the formal charges against Respondent. This letter was sent by certified mail, return receipt requested, to Respondent at 4206 Elmgrove Court, Arlington, Texas 76015. The notice was received by Respondent on January 24, 2000, as indicated by her signature of the green return receipt.

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

4. In 1987, Respondent opened a home health agency, Brown County Visiting Nurses, Inc. (Agency), in Early, Texas.

5. In 1995, Respondent moved approximately 140 miles from Early to Arlington, Texas, and she remained as the supervising registered nurse (RN) for the Agency.

6. Respondent did not provide an alternate supervising RN for the Agency.

7. Respondent was in the office in Early, Texas, only about four days per month.

8. Respondent allowed a licensed vocational nurse and an unlicensed staff member to complete documentation and sign her name to it.

9. Respondent did not perform supervisory aid visits every 14 days.

10. Respondent was not aware that she had patients who did not qualify for home health care because they were not homebound.

11. Respondent had patients who had never met or seen her.

    a. Patient EA never met Respondent and did not know who she was.

    b. Patient T.S. had wounds on his feet that had not been properly assessed and treated by Respondent. The patient and his family had never met Respondent.

12. An Agency patient was found to be severely ill and had to be hospitalized. The patient could not recall the last time that she saw a nurse.

13. Respondent unnecessarily exposed her patients to risk of harm.

V. PROPOSED CONCLUSIONS OF LAW

1. The Board of Nurse Examiners (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. §§ 301.001 *et seq* (formerly TEX. REV. CIV. STAT. ANN art. 4513 *et seq).*

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. Ch. 2003.

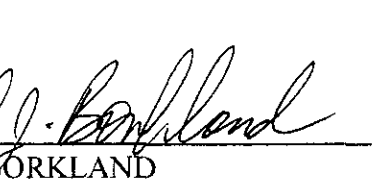
3. The Respondent received proper and timely notice of the intention to institute disciplinary action and of the hearing, pursuant to TEX. GOV'T CODE ANN. Ch. 2001.

4. Based on Findings of Fact Nos. 5-13, Respondent unnecessarily exposed her patients to risk of harm in violation of 22 TEX. ADMIN. CODE (TAC) §217.11 (7), (15) and (16), 25 TAC §115.21 (4) (G), 45 Code of Federal Regualtion (CFR) § 484 (12) (c) and 36 (d) (2).

5. Based on Findings of Fact Nos. 5-13, and Conclusion of Law No. 4, Respondent failed to conform to minimum standards associated with nursing in violation of TEX. REV. CIV. STAT. ANN. art 4525(b)(12), now TEX. OCC CODE ANN. § 301.452 (13).

6. Based on Findings of Fact Nos. 5-13, and Conclusions of Law Nos. 4 and 5, the Board should issue a reprimand with stipulations against Respondent's nursing license.

SIGNED this 6th day of October, 2000.



MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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DOCKET NO. 507-00-1226

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

ORDER OF THE BOARD

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

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

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

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

DOCKET NUMBER 507-00-1226

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

STAFF'S PROPOSED SANCTIONS AND STIPULATIONS

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

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

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

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience must include registered nurses. It must be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure.

EXHIBIT A

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. The course must be a minimum of six (6) hours in length. In order for the course to be approved, the target audience must include registered nurses. The course must contain content on the following: guidelines and processes for good reporting and recording; legal guidelines for recording; methods of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board has for relicensure.

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

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

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

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

(7) RESPONDENT SHALL be supervised by a registered nurse who is on the premises. The supervising RN is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided by the Board, periodic reports as to RESPONDENT's capability to practice professional nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted to the office of the Board at the end of each three (3) months for one year(s) of employment as a professional nurse.

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

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

Entered this 14th day of November, 2000.

BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

BY: Katherine A. Thomas

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