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

Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 758255	§	
issued to DEBORAH LYNN OTTO	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boai considered the matter of DEBORAH LYNN OTTO, Registered Nurse License Number 758255, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on October 7, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from El Centro College, Dallas, Texas, on May 8, 2008. Respondent was licensed to practice professional nursing in the State of Texas on July 15, 2008.

5. Respondent's professional nursing employment history includes:

08/08 - 02/09	RN	Baylor University Medical Center Dallas, Texas

Respondent's professional nursing employment history continued:

02/09 - Present	RN	Elim Medical Staffing Dallas, Texas
03/09 - Present	RN	American Healthcare LLC Dallas, Texas
03/09 - 05/09	RN	Presbyterian Hospital of Dallas Dallas, Texas
05/09 - Present	RN	Dallas Regional Medical Center Dallas, Texas

6. At the time of the initial incident, Respondent was employed as a registered nurse with Baylor University Medical Center, Dallas, Texas, and had been in this position for six (6) months.

7. On or about February 10, 2009, while employed with Baylor University Medical Center, Dallas, Texas, Respondent failed to administer Ancef to Patient LTR#00094024, as ordered by the physician. Additionally, Respondent inaccurately documented that she administered Ancef to Patient LTR#00094024 in the patient's medication administration record and/or nurse's notes. Respondent's conduct created an inaccurate medical record and was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states that the allegation is false.

9. On or about February 10, 2009, while employed with Baylor University Medical Center, Dallas, Texas, Respondent failed to accurately verify a medication in the electronic medication administration record in that she verified Tranexamic Acid for Patient LTR#00678097 which had no order documented in the medical record. Respondent's conduct created an inaccurate medical record and was likely to injure the patient in that subsequent care givers would rely on her documentation on which to base their decisions for further medical care.

10. In response to the incident in Finding of Fact Number Nine (9), Respondent states that the facility began using a new computer software program that she was unfamiliar with.

11. On or about February 10, 2009, while employed with Baylor University Medical Center, Dallas, Texas, Respondent failed to note and implement orders for a blood transfusion for Patient LTR#00725138-004. The order was written at 1600, and patient's blood transfusion was not started until seven (7) hours later by the oncoming shift at 2300. Respondent's conduct delayed the onset of medical treatment that was needed to prevent further complications.

12. In response to the incident in Finding of Fact Number Eleven (11), Respondent states:

"Normally the secretary told me in person if I had a blood transfusion coming up because she had to put in an order for a type and crossmatch ahead of time. If the order was written at 1600, then I don't know how long the chart was sitting on the secretary's desk before she input the orders. I also don't know if the type and crossmatch was completed before I finished my shift at 7pm. Second shift had a habit of complaining if they had to give blood. They didn't like to do it, and would usually be mad if first shift didn't work overtime to take care of it. Also, second shift should not have waited 4 hours to do a chart check. This was a unit that didn't work well together as a team, and team players are absolutely essential to ensure patient safety and holistic care."

13. On or about February 10, 2009, while employed with Baylor University Medical Center, Dallas, Texas, Respondent inaccurately documented that she administered Tylenol and Benadryl to Patient LTR#00725138-004 in the patient's medication administration record and/or nurse's notes. Respondent's conduct created an inaccurate medical record and was likely to injure the patient in that subsequent care givers would rely on her documentation on which to base their decisions for further medical care.

14. In response to the incident in Finding of Fact Number Thirteen (13), Respondent states:

"My recollection of this situation is that I did give the Tylenol and Benadryl...I would never falsely chart that I had given a medication unless I truly believed I had given it."

15. On or about February 10, 2009, while employed with Baylor University Medical Center, Dallas, Texas, Respondent failed to accurately and completely document a telephone order for Patient LTR#00844242 to be NPO after midnight, and to start intravenous fluids, in the patient's medical record and/or nurse's notes. Additionally, Respondent failed to notify the oncoming shift nurse of these orders during report. The physician later found Patient LTR#00844242 eating breakfast the following morning which resulted in the patient's scheduled surgery being cancelled. Respondent's conduct created an inaccurate medical record and may have injured the patient in that it delayed the medical care that was needed to prevent possible complications.

16. In response to the incident in Finding of Fact Number Fifteen (15), Respondent states:

"All of the nurses at Baylor are required to carry telephones around with them while in the patient's rooms. I was in the middle of a procedure in a patient's room, when the phone rang. The doctor told me to make a patient NPO at midnight, but I remember absolutely nothing regarding IV fluids. I made a note, but when I was finished with the patient's procedure, I forgot. My recollection is that I did mention that the patient was supposed to be NPO after midnight to the oncoming nurse during report. It had been an extremely busy day, and by the time I have report, I had completely forgotten that I had not written the order in the chart."

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(C)&(D) and 217.12(1)(A), (1)(B),(1)(C)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 758255, heretofore issued to DEBORAH LYNN OTTO, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

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

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

IT IS FURTHER AGREED and ORDERED that while Respondent's license(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 AGREED 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.state.tx.us/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully

complete a course in medication administration. 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. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

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

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND

PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE 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. 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. 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) RESPONDENT SHALL be supervised by a Registered Nurse who is on the

premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(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 Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

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

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 1 day of November 2011.

Deborah Lynn Otto

DEBORAH LYNN OTTO, Respondent

Sworn to and subscribed before me this 1 day of November, 2011.

SEAL

KYLE O'FARRELL
Notary Public, State of Texas
My Commission Expires
November 19, 2013

K O'Farrell

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 1st day of November, 2011, by DEBORAH LYNN OTTO, Registered Nurse License Number 758255, and said Order is final.

Effective this 13th day of December, 2011.

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