



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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse           §     AGREED  
License Number 664359                       §  
issued to DENYCE ELAINE FONTAINE       §     ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that DENYCE ELAINE FONTAINE, Registered Nurse License Number 664359, hereinafter referred to as Respondent, may have violated Section 301.452 (b)(10)&(13), Texas Occupations Code.

An informal conference was held on April 27, 2010, at the office of the Texas Board of Nursing, in accordance with Section 301.464, Texas Occupations Code.

Respondent appeared in person. Respondent was notified of her right to be represented by legal counsel and elected to waive representation by counsel. In attendance were Mary Beth Thomas, PhD, RN, Executive Director's Designee; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Bonnie Cone, MSN, RN, Nurse Consultant; Skylar Caddell, RN, Legal Nurse Investigator; Dominique Mackey, Investigator; and Nancy Krause, RN, Investigator.

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.
2. Respondent waived representation by counsel, notice and hearing, and consented 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 Our Lady of the Lake College of Nursing, Baton Rouge, Louisiana, on May 1, 1993. Respondent was licensed to practice professional nursing in the State of Texas on October 4, 1999.

5. Respondent's nursing employment history includes:

6/1993 - 11/1995	Staff Nurse	Our Lady of the Lake Hospital Baton Rouge, Louisiana
11/1995 - 11/1996	Case Manager Staff Nurse	Supra Home Health Care Louisiana
11/1996 - 3/1999	Case Manager Staff Nurse	A-One Home Health Care Louisiana
4/1999 - 10/1999	Unknown	
11/1999 - 9/2004	Staff Nurse	Outreach Home Health Care Sherman, Texas
10/2004 - 6/2005	Staff Nurse	Quality Home Health Sherman, Texas
10/2004 - 6/2005	Staff Nurse	Jordan Home Health Sherman, Texas
6/2005 - 8/2005	Staff Nurse	Wilson N. Jones Medical Center Sherman, Texas
9/2005 - 3/2006	Unknown	
4/2006 - 10/2007	Staff Nurse	Brentwood Place Denison, Texas
11/2007 - Present	Staff Nurse	Angels of Care Pediatric Home Health Howe, Texas

6. At the time of the incidents in Findings of Fact Seven (7), and Nine (9), Respondent was employed as a Staff Nurse with Wilson N. Jones Medical Center, Sherman, Texas, and had been in this position for one (1) month.

7. On or about July 17, 2005, while employed with Wilson M. Jones Medical Center, Sherman, Texas, Respondent failed to obtain an order from the physician to discontinue the intravenous infusion for Patient 04519, when the intravenous (IV) site became unuseable. Respondent's conduct deprived the physician of information that the patient was unable to receive IV fluids as ordered, which could have resulted in nonefficacious treatment.
8. In response to the incident in Finding of Fact Number Seven (7), Respondent states she was attempting to find the Charge Nurse and planning to contact the physician when the patient's spouse came out of the room and stated the patient was shaking and the blood sugar was low. Respondent states she went immediately to assist the patient and was delayed in being able to notify the physician that the IV site was unuseable.
9. On or about July 17, 2005, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent failed to notify the Charge Nurse the intravenous site for Patient 04519 had become unuseable and was discontinued. Respondent's conduct deprived the patient of timely intervention and reestablishment of an intravenous site to continued fluid administration, which could have resulted in nonefficacious treatment.
10. In response to the incident in Finding of Fact Number Nine (9), Respondent states she hadn't attempted to initiate an Intravenous(IV) access site in many years and attempted to find another nurse to re-establish the IV site for this patient. Respondent states that when she couldn't locate an available nurse she then attempted to locate the Charge Nurse and was unable to find her.
11. At the time of the incident in Finding of Fact Twelve (12), Respondent was employed as a Staff Nurse with Brentwood Place, Denison, Texas and had been in this position for one (1) year and four (4) months.
12. On or about August 1, 2007 through October 7, 2007 while employed as a Staff Nurse with Brentwood Place, Denison, Texas, Respondent failed to renew her nursing licence and consequently practiced professional nursing on a delinquent Texas Registered Nurse license. Respondent's conduct deceived residents, their families, fellow care givers, and the public in that they believed Respondent's nursing practice was in compliance with all Board Rules and Regulations.
13. In response to the incident in Finding of Fact Twelve (12), Respondent states a close family member had been diagnosed with terminal breast cancer and metastasis. Respondent states she was emotionally preoccupied and she forgot to renew her license.

14. On or about June 3, 2007, through the present, Respondent may have lacked fitness to safely practice nursing due to mental health and/or cognitive impairment, as indicated by her inability to answer questions and follow thought processes during a conference with Board Investigators, as well as by recurrent grief and decision making problems triggered by events which reminded her of her mother's medical condition and death. Respondent's condition could have affected her ability to recognize subtle signs, symptoms or changes in patients' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.
15. In response to the incident in Finding of Fact Fourteen (14), Respondent states she was nervous during the conference.
16. On July 19, 2010, Respondent underwent a Neuropsychological Evaluation by Dr. Ronald G. Paulman, Ph.D. Clinical Neuropsychology. Dr. Paulman's findings indicate that Respondent continues to possess cognitive skills important to her nursing practice with generally good planning and organization under most circumstances, with some variability in executive processing and shows a degree of anxiety that may become more disabling for her when she is in circumstances of high demand or time pressures. Dr. Paulman opines that Respondent would likely remain more vulnerable to lapses in a hospital-based setting, with the necessity to attend to multiple demands, rapidly evolving circumstances, and attendant time pressures. Dr. Paulman concludes that the evaluation finds few signs of any emergent neurocognitive dysfunction and current results suggest few contraindications to Respondent's continued successful function in the role of home health nurse. Additionally, Dr. Paulman reports that Respondent submitted current employment evaluations which indicated exceptional performance of her job duties.

#### 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),(12)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B)&(1)(C) and 22 TEX. ADMIN. CODE §217.12(1)(B),(4)&(5).
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 664359, heretofore issued to DENYCE ELAINE FONTAINE, including revocation of Respondent's license to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, 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 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, 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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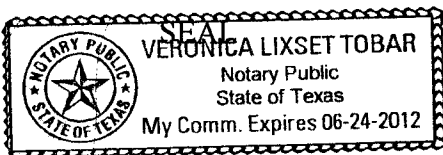
RESPONDENT'S CERTIFICATION

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 when this Order becomes final and the terms of this Order become effective, 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 13<sup>th</sup> day of December 2010

Denyce Elaine Fontaine  
DENYCE ELAINE FONTAINE, RESPONDENT

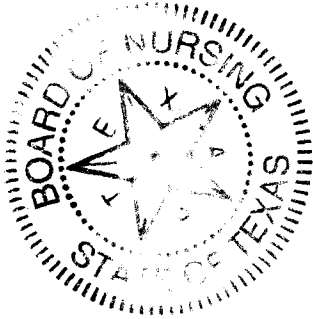
Sworn to and subscribed before me this 13<sup>th</sup> day of December, 2010.




Veronica Lixset Tobar  
Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 13th day of December, 2010, by DENYCE ELAINE FONTAINE, Registered Nurse License Number 664359, and said Order is final.



Effective this 20th day of December, 2010.

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