



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.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of § AGREED
Registered Nurse License Number 601019 §
& Vocational Nurse License Number 83013 §
issued to JACQUELYN CHLO GRIGGS § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board produced evidence indicating that JACQUELYN CHLO GRIGGS, hereinafter referred to as Respondent, Registered Nurse License Number 601019 and Vocational Nurse License Number 83013, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on August 28, 2007, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was represented by William Hopkins, Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; Victoria Cox, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Mike Abul-Saud, RN, Investigator; and J. L. Skylar Caddell, RN,C, Lead Investigator. The conduct outlined in Findings of Fact Numbers Seven (7) through Twelve (12) below were discussed during said informal conference. The conduct outlined in Findings of Fact Numbers Sixteen (16) through Eighteen (18) occurred after the aforementioned informal conference.

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 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. Respondent's license to practice vocational nursing in the State of Texas is currently in "delinquent" status.
4. Respondent received a Certificate in Vocational Nursing on August 17, 1979; received an Associate Degree in Nursing from San Jacinto College, Pasadena, Texas on December 17, 1993; and received a Certificate from The University of Texas Medical Branch School of Nurse Midwifery, Galveston, Texas on April 27, 2001. Respondent was licensed to practice vocational nursing in the State of Texas on October 16, 1979; was licensed to practice professional nursing in the State of Texas on March 15, 1994; became Board recognized as a Nurse Midwife in the State of Texas on July 29, 2002; and became Board recognized with Prescriptive Authority as a Nurse Midwife in the State of Texas on November 18, 2002.
5. Respondent's nursing employment history includes:

10/1979 - 1981	Staff Nurse, LVN	Planned Parenthood Houston, Texas
1981 - 1984	LVN Office Nurse & Manager	Jay T. Rahu, MD Anchorage, Alaska
1984 - 1986	LVN Staff Nurse, Labor & Delivery	Coronado Community Hospital Pampa, Texas
1986 - 1987	LVN Staff Nurse, Thoracic Surgery	St. Anthony's Hospital Amarillo, Texas
1988 - 1989	Unknown	
1990 - 1994	Staff Nurse, LVN/RN Lay Midwife	Pasadena Midwives Birth Center Pasadena, Texas
1994 - 2005	RN Owner, Lactation Consultant, Nurse Midwife	Gentle Care Midwifery Services Houston, Texas
07/2001 - Unknown	Adjunct Professor	San Jacinto College South Nursing Program Houston, Texas
12/2001 - Unknown	Nurse Midwife	Doctor's Hospital Houston, Texas
2005 - Present	Nurse Midwife Owner/Director	Bay Area Birth Center Pasadena, Texas

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, and had been in this position for less than one (1) year.
7. On or about September 1, 2005, through July 14, 2006, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to appropriately complete detailed Risk Assessments of patients' family histories and risk factors regarding their pregnancies. Although Respondent completed detailed family histories, the Risk Assessment forms Respondent documented did not include or identify a complete set of relevant pregnancy risk factors, and did not include any plans or interventions for risk factors that were identified. Respondent's conduct was likely to injure patients and their developing fetuses from possible complications due to undetected risk factors.
8. On or about November 23, 2005, through July 9, 2006, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to create and maintain appropriate and complete medical plans of care for patients at risk for complicated, abnormal pregnancies, including patients at increased risk for uterine rupture due to previous Cesarean sections, as follows:
 - November 23, 2005, through June 20, 2006, for Patient Number 05250601;
 - December 8, 2005, through July 9, 2006, for Patient Number 07090601; and
 - June 15, 2006, through July 9, 2006, for Patient Number 07150601.Respondent's conduct was likely to injure patients, including their developing fetuses, from medical care based upon information derived from incomplete and/or inappropriate plans of care.
9. On or about July 9, 2006, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to call 911 in order to use an emergency services equipped vehicle, as appropriate and according to the facility's policy, to transport the aforementioned Patient Number 07090601 to a nearby emergency center after the patient's labor failed for more than five (5) hours to progress toward delivery of the second of her twins. Instead, Respondent transported the patient using a private vehicle. Respondent's conduct was likely to injure the patient and her unborn baby from possible complications occurring while en route and while without equipment necessary to manage the patient's care.
10. On or about July 14, 2006, through July 15, 2006, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to assess and monitor the vital signs periodically, as well as perform vaginal examinations, of the aforementioned Patient Number 07150601 while the patient remained in the facility overnight waiting to see if her irregular contractions would progress toward active labor. The patient had undergone a previous Cesarean section due to placental abruption the year before, which increases the risk of uterine rupture during subsequent pregnancies or labor. Nine (9) hours and thirty (30) minutes after arriving at the facility, Respondent heard the patient moaning and complaining of being very uncomfortable. When Respondent checked the

patient's fetal heart rate, she found that it was at a critical rate of 74, after having been 130 - 150 earlier. Although Respondent immediately began to administer oxygen to the patient, she failed to call 911 in order to use an emergency services equipped vehicle, as appropriate and according to the facility's policy, to transport the patient to a nearby emergency center. Instead, Respondent transported the patient using a private vehicle. After an emergency Cesarean section was performed, the baby was delivered stillborn and it was determined that the patient had suffered a uterine rupture. Respondent's conduct may have contributed to the patient suffering a uterine rupture and to the baby's demise.

11. On or about August 16, 2006, Respondent, as Administrator of Bay Area Birth Center, Pasadena, Texas, entered into an Agreed Order with the Department of State Health Services (DSHS), which found that from on or about February 15, 2006, through March 29, 2006, Bay Area Birth Center, Pasadena, Texas, established and engaged in the business of providing birthing center services without holding an appropriate Department-issued license as a birthing center. A copy of the Agreed Order, dated August 16, 2006, is attached and incorporated herein by reference as part of this Order. Respondent's conduct mislead patients and the public.
12. In response to the incidents in Findings of Facts Numbers Seven (7) through Eleven (11), Respondent states that each patient had the standard plan of care for abnormal pregnancies, but admits that she did not create and maintain an appropriate plan of care for Patient Number 07150601 because of Respondent's late involvement in the patient's care. Respondent states that she is now more diligent in questioning and documenting previous health issues, and that she no longer accepts as patients pregnant women who have previously undergone a Cesarean section. Additionally, Respondent states that as a result of the incident involving Patient Number 07150601, the risk assessment forms used by the facility have been completely revised and have been completed for all patients, and that her "Vaginal Birth After Caesarean" protocols have been updated. Regarding the Agreed Order with DSHS, Respondent states the matter arose after she filed the initial application for licensure as a birthing center and DSHS did not immediately complete an initial survey visit. Once the survey was completed, DSHS made the initial licensure date retroactive back to March 1, 2006; however, Respondent states she had provided birthing center care to some patients prior to the actual license being issued. Regarding Patient Number 07090601, Respondent states that the option of calling 911 was raised, but because the patient was not in a critical situation and because the hospital was only three blocks away, she decided that the patient could be safely transported via private car. Respondent states that the second infant was delivered with no health problems soon after arrival at the hospital. Regarding the July 14, 2006, through July 15, 2006, incident with Patient Number, Respondent states that the patient arrived without ruptured membranes and was still a week before her due date. After the patient's husband asked if they could rest in one of the birth rooms, Respondent states she agreed and then left them alone, while resting herself in an adjacent room so that she could listen for sounds of unusual activity. Once Respondent realized there was a problem, she states she realized that using a private vehicle would prevent the use of a fetal monitor during transport, but believed it was still the best option considering the amount of fetal distress that was already present.

13. On or about February 14, 2007, Respondent successfully completed the course, "2007 Texas Nursing Law," a five (5) contact hour course provided by Southwest Seminars Association, Inc., Houston, Texas.
14. Formal Charges were filed on November 19, 2007.
15. Formal Charges were mailed to Respondent at her address of record on November 19, 2007.
16. On or about January 6, 2008, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to timely transport Patient AV, who had a history of retained placenta from a previous delivery, to an emergency care center after the patient delivered a viable female neonate but did not deliver the placenta, which should occur within thirty (30) to forty-five (45) minutes. Instead, Respondent delayed for more than ninety (90) minutes while documenting that the patient had both minimal bleeding in one part of the medical record and moderate bleeding during the same time in another part of the medical record. Emergency Medical Services noted that the patient had heavy bleeding upon their arrival to transport the patient, and upon arrival at a local emergency department, the patient had lost an estimated 500 cc of blood. The patient required surgical removal of the placenta and was discharged two (2) days later. Respondent's conduct was likely to injure the patient from complications of bleeding and retained placenta, including shock, inversion of the uterus, and possible demise.
17. On or about May 3, 2008, while employed as the Nurse Midwife Owner/Director of Bay Area Birth Center, Pasadena, Texas, Respondent failed to timely transport the newly delivered infant of Patient MS to an emergency care center when Respondent suctioned the infant and obtained 6 cc of meconium stained fluid nine (9) minutes after the infant was delivered with blue extremities and weak cry. During the next eighty-five (85) minutes, the infant continued to show signs of respiratory distress and was unable to maintain a blood oxygen level of more than 76% even with supplemental oxygen before Respondent called for an ambulance. The infant was admitted to the Neonatal Intensive Care Unit of a local hospital, diagnosed with respiratory failure and aspiration pneumonia, and subsequently recovered. Respondent's conduct was likely to injure the infant from complications of low blood oxygen, including possible brain damage and/or demise.
18. In response to the incidents in Findings of Fact Numbers Sixteen (16) and Seventeen (17), Respondent states that "Obviously, transferring of a patient to the hospital is a last resort and both the patient and I try to avoid it as much as possible. According to Respondent, Patient AV was appropriately screened before the delivery and that according to her policies and protocols, the patient was transferred at the appropriate time. Respondent indicates that she subsequently notified the patient she would be unable to provide her future birthing center services due to the patient's predisposition for retained placenta. Regarding the infant of Patient MS, Respondent admits that in hindsight, if she had to do it over again, she would probably have transferred the infant a bit sooner while stating her belief that her decision to wait was not wrong, that the time frame was appropriate, and that at the time it seemed reasonable to give the infant a chance to transition, adjust, and respond.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 217.11(1)(A),(1)(B),(1)(D), (1)(M),(3)(A)&(4)(A), 217.12(1)(A),(1)(B)&(4) and 221.13(a).
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 601019 and Vocational Nurse License Number 83013, heretofore issued to JACQUELYN CHLO GRIGGS, including revocation of Respondent's licenses 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 Registered Nurse License Number 601019 and Vocational Nurse License Number 83013, previously issued to JACQUELYN CHLO GRIGGS, to practice nursing in Texas are hereby SUSPENDED and said suspension is ENFORCED until Respondent completes provides documentation of successful completion of the following requirements:

(1) RESPONDENT SHALL 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 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>.

(3) RESPONDENT SHALL 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 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 licenses 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 State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that, upon verification of successful completion of the above requirements, the SUSPENSION will be STAYED, and RESPONDENT will be placed on PROBATION for two (2) years under the following agreed terms:

(4) 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 §211.01 *et seq.* and this Order.

(5) RESPONDENT SHALL pay all re-registration fees, if applicable, and be issued licenses to practice nursing in the State of Texas.

(6) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete an academic course in advanced practice physical assessment with a minimum

passing grade of not less than “C” or “Pass” if using a “Pass/Fail” grading system. The academic course SHALL BE for at least three (3) semester credit hours, including not less than one (1) semester credit hour, or three (3) clock hours per week, of clinical practicum. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Instruction SHALL BE provided by an Advanced Practice Registered Nurse. RESPONDENT SHALL perform physical assessments on live patients in the clinical practicum component; performing assessments on mock patients or mannequins WILL NOT be accepted. 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, available from the Board’s website at <http://www.bon.state.tx.us/disciplinaryaction/pdfs/i17.pdf>, 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 and in addition to any continuing education requirements the Board has for relicensure.

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 PROBATION CONDITIONS FOR TWO (2) YEARS 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) WITH ADVANCED PRACTICE AUTHORIZATION WILL NOT APPLY TO THIS PROBATIONARY PERIOD:

(7) RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the probation conditions on RESPONDENT's licenses. 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.

(8) 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.

(9) For the first year of employment as a Certified Nurse Midwife under this Order, RESPONDENT SHALL be directly supervised by Patricia A. Jones, RN, Certified Nurse Midwife. Direct supervision requires Patricia A. Jones, RN, Certified Nurse Midwife, 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 contract for services. Multiple employers are prohibited.

(11) For the first one (1) year of employment as a Certified Nurse Midwife under this Order, 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 Patricia A. Jones, RN, Certified Nurse Midwife, in her capacity of supervising RESPONDENT. These reports shall be submitted by Patricia A. Jones, RN, Certified Nurse Midwife, to the office of the Board at the end of each three (3) months for one (1) year of employment as a nurse.

(13) For the remainder of the probationary period, RESPONDENT'S PRACTICE SHALL be monitored by Patricia A. Jones, RN, Certified Nurse Midwife. The monitor must identify and document individualized goals and objectives, resources to be utilized, and the methods to be used to determine successful completion of the monitoring period relative to the violations identified in this Order. Respondent shall meet with the monitor at least twice a month, for a minimum of one (1) hour each session. Respondent shall ensure that the monitor submits reports addressing Respondent's progress toward achievement of the identified monitoring goals and objectives to the office of the Board at the end of each three (3) month period for the remainder of the probationary period. Meetings may be longer and more frequent if the monitor determines necessary. If either improvement of documentation and/or physical assessment skills is a goal or objective of the monitoring, Respondent shall perform assessments on and document assessment findings for live patients. Performing assessments on and documenting findings for mock patients or mannequins will not be accepted. Multiple employers are prohibited.

IT IS FURTHER AGREED and ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license, 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 AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S licenses 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 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 licenses to practice nursing in the State of Texas, as a consequence of my noncompliance.

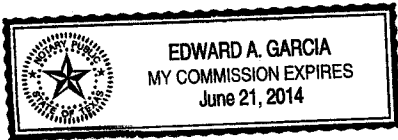
Signed this 26th day of October, 2010.

Jacquelyn Griggs, CNM
JACQUELYN CHEO GRIGGS, Respondent

Sworn to and subscribed before me this 26 day of October, 2010.

SEAL

Edward A Garcia
Notary Public in and for the State of Texas

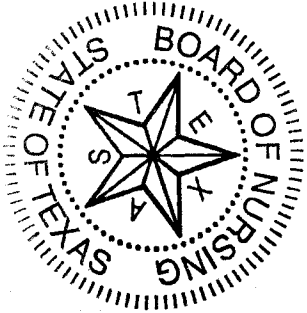



Approved ~~to form and submit~~
William Hopkins
William Hopkins, Attorney for Respondent

Signed this 26 day of October, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 26th day of October, 2010, by JACQUELYN CHLO GRIGGS, Registered Nurse License Number 601019 and Vocational Nurse License Number 83013, and said Order is final.

Effective this 14th day of December, 2010.




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

DOCKET NO. A5484-520-2006

**IN THE MATTER OF
BAY AREA BIRTH CENTER
PASADENA, TEXAS**

**§
§
§
§
§**

**BEFORE THE
DEPARTMENT OF
STATE HEALTH SERVICES
AUSTIN, TEXAS**

AGREED ORDER

I. JURISDICTION

The Department of State Health Services ("Department"), Regulatory Services Division, Enforcement Unit, is authorized to enforce the Texas Birthing Center Licensing Act under Chapter 244 of the Texas Health and Safety Code ("Act"), and the Department Rules at 25 Texas Administrative Code (TAC) Chapter 137 ("Rules") governing the licensing and regulation of birthing centers in Texas.

II. RESPONDENT

Bay Area Birth Center ("Respondent") holds a Department-issued license as a birthing center, license number 008338, and is subject to the aforementioned Act and Rules.

III. FACTS

On or about March 28, 2006, the Department conducted an on-site initial inspection ("inspection") of Respondent at 3210 Strawberry Road, Pasadena, Texas 77504. The purpose of the Department's inspection was to determine Respondent's compliance with the aforementioned Act and Rules as an applicant for a birthing center license.

The Department finds that Respondent engaged in the conduct more specifically described in the Department's Notice of Violation ("Notice"), dated May 4, 2006, and as addressed in section "B. Enforcement, paragraph 3" herein. The Notice is incorporated in this Agreed Order ("Order") by reference.

The Department concludes that Respondent's conduct violated the Act under § 244.003(a) and the Department Rule at 25 TAC § 137.1(c), as set forth under section "B. Enforcement, paragraphs 2 and 3" herein. The Department further finds that disciplinary action against Respondent is warranted and authorized as set forth herein, pursuant to § 244.015 of the Act.

IV. NOTICE

Through delivery of the Notice, the Department informed Respondent of its intent to impose an administrative penalty, in the amount of \$27,300.00, against Respondent, for violations alleged in the Department's Notice.

V. RESPONSE

Respondent replied to the Department's Notice by making a written request for an informal conference and a hearing. On or about June 8, 2006, Respondent's legal counsel, William Hopkins, notified the Department, in writing, of his representation of Respondent in this matter.

VI. SETTLEMENT

A. INFORMAL CONFERENCE

On July 19, 2006, an informal conference was held between Department staff, Respondent and Respondent's legal counsel.

Representatives for the Department, Respondent and Respondent's legal counsel determined that a settlement of these matters would be in the best interests of the parties. The terms of the settlement are contained in this Order.

B. ENFORCEMENT

The Department and Respondent have agreed to the following:

1. The Department withdraws its initial proposal to impose an administrative penalty, in the amount of \$27,300.00, against Respondent.
2. The Department hereby imposes an administrative penalty against Respondent, in the amount of \$3,500.00, for Respondent's violation of the Act and the Department Rule as described in section "III. Facts" of this Order.
3. The Department and Respondent have agreed that Respondent be assessed an administrative penalty in the amount of \$500.00 for each infant delivered in Respondent's birthing center when Respondent held no Department-issued birthing center license (seven infants), for a total administrative penalty imposed in the amount of \$3,500.00.
4. The administrative penalty, in the amount of \$3,500.00 shall be remitted within 30 days from the date the Commissioner of the Department, or his designee, signs this Order. Respondent will remit a cashier's check, money order, or company check made payable to the Department of State Health Services, and must bear the notation, "Deposit in Budget #ZZ101, Fund #996." Respondent shall mail the administrative penalty payment of \$3,500 to: Division for Regulatory Services, Enforcement Unit, Department of State Health Services, 1100 West 49th Street, Austin, Texas, 78756.
4. Respondent shall comply with this Order and shall remain in compliance with all applicable laws, rules and regulations governing birthing centers.

VII. COMPLETE AGREEMENT

This Order is made pursuant to Chapter 2001 of the Texas Government Code, § 2001.056(2), and the procedural rules adopted by the Department. This Order represents the complete settlement of all allegations contained in the Notice, as described in sections "III. Facts," "IV. Notice" and "VI. Settlement B. Enforcement" of this Order.

A. WAIVER OF APPEAL AND AGREEMENT REGARDING SIGNATURE

In exchange for the execution of this Order, Respondent waives the right to an administrative hearing and any judicial review of this Order. Respondent has no objection to this Order being signed by either the Commissioner of the Department or his designee.

B. NO WAIVER WITH REGARD TO OTHER VIOLATIONS

The Department does not waive the right to enforce this Order or to prosecute any other violations that Respondent may commit and may consider this Order in the processing of any other enforcement actions.

C. COMPLETE UNDERSTANDING

The Respondent acknowledges understanding of the terms of this settlement agreement, enters into the settlement agreement freely, and agrees to the terms and conditions of this Order.

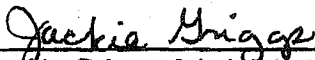
NOW THEREFORE, IT IS ORDERED that:

- 1) The Department's initial proposal to impose an administrative penalty, in the amount of \$27,300.00, is hereby withdrawn;
- 2) Respondent violated the Act and the Department Rule as set forth in section "VI. Settlement B. Enforcement #'s 2 and 3." of this Order;
- 3) Respondent is hereby assessed an administrative penalty in the total amount of \$3,500.00. Payment by Respondent, in the amount of \$3,500.00 shall be remitted within 30 days from the date the Commissioner of the Department, or his designee, signs this Order, in accordance with section "VI. Settlement B. Enforcement #4." of this Order; and
- 4) Respondent shall henceforth comply with this Order and with all applicable laws, rules and regulations. Failure to comply may result in additional enforcement action.

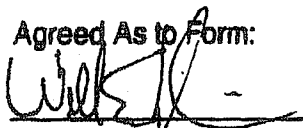
Ordered this 16th day of, August, 2006.


 Richard B. Bays, Assistant Commissioner
 Division for Regulatory Services

Agreed As to Form and Substance:


 Jackie Griggs, Administrator
 Bay Area Birth Center
 License Number 008338

7-31-06
 Date of Ms. Griggs' Signature

Agreed As to Form:

 William Hopkins, Attorney at Law, Counsel
 for Respondent, Thompson & Knight L.L.P.