



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 538230 §
issued to REBECCA ANN NIEMAN § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board.

~~considered the matter of REBECCA ANN NIEMAN, Registered Nurse License Number 538230,~~
hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to 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 approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on May 17, 2013, 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 Meridian Junior College, Meridian, Mississippi, on May 1, 1977. Respondent was licensed to practice professional nursing in the State of Texas on April 9, 1987.
5. Respondent's professional nursing employment history includes:

1977 - 1989 Unknown

Respondent's professional nursing employment history continued:

1989 - 1990	Triage Referral Nurse	Ask A Nurse-Huguley Hospital Burleson, Texas
1990 - 1992	Claims Documentation Coordinator	Psychiatric Institute of Fort Worth, Fort Worth, Texas
1992 - 1996	Clinical Manager	Harris Home Health Services Fort Worth, Texas
1993 - 1994	PRN Staff Nurse	CPC Oak Bend Hospital Fort Worth, Texas
1996 - 1997	Patient Care Coordinator	Apex Home Health Services Fort Worth, Texas
1997 - 1998	Director of Continuous Improvement	Home and Community Medical Burleson, Texas
1998 - 1999	Continuous Improvement	Cardiovascular Home Care Fort Worth, Texas
1999 - 2006	Performance Improvement Specialist	Vitas Hospice Fort Worth, Texas
2007 - 2011	Clinical Nurse Reviewer/ Medical Coder	Leprechaun Outsource Management Fort Worth, Texas
02/2011 - 06/2011	Clinical Field Staff Supervisor	Encompass Home Health North Central Texas Fort Worth, Texas
07/2011 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Clinical Field Staff Supervisor with Encompass Home Health North Central Texas, Fort Worth, Texas, and had been in this position for five (5) months.
7. On or about July 11, 2011, while employed as a Clinical Field Staff Supervisor with Encompass Home Health North Central Texas, Fort Worth, Texas, Respondent failed to ensure that Patient Medical Record Number FTW000060904201 was timely assessed by a nurse after the patient reported that she had not been seen by a nurse. Because the patient's

case manager had assessed the patient the day before for resumption of services after the patient was treated and discharged from the hospital for acute exacerbation of Chronic Obstructive Pulmonary Disease, Respondent only attempted to call the patient, leaving a message when she did not reach the patient, and then emailed the information to the patient's case manager. Approximately two (2) hours later, Respondent informed the case manager of the patient's request when the case manager called in response to the email. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to delayed detection and assessment of changes of condition.

8. On or about July 21, 2011, while employed as a Clinical Field Staff Supervisor with Encompass Home Health North Central Texas, Fort Worth, Texas, Respondent failed to report that the oxygen saturation of the aforementioned Patient Medical Record Number FTW000060904201 was found by a physical therapist to be critically low at 68%, and the Oxygen concentrator in use was not functioning properly. Respondent failed to report the patient's condition to the case manager, report the malfunction to the equipment service company, and send a nurse to assess the patient and the equipment. Instead, Respondent simply sent an email to the case manager. Seven (7) hours later, the case manager called Respondent to discuss the patient; however, about thirty (30) minutes after the phone call, the police notified the facility that the patient had been found deceased in the home. Respondent's conduct was exposed the patient unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes which may have contributed to the patient's demise.
9. In response to Findings of Fact Numbers Seven (7) and Eight (8), Respondent states that she did report to the patient's case manager that the patient had called the physician to report that there was no nurse visit. Respondent further states she did not document the conversation. Respondent states that she emailed the patient's case manager about 10:30 am and 11:00 a.m. to report the patient's oxygen saturation level, and the patient's case manager returned her call at approximately 5:30 pm to confirm that she had received the email. Respondent states the case manager told her the patient was noncompliant by taking her oxygen off many times throughout the day to go smoke and did not think a visit was necessary. Respondents states she believes she acted prudently as a registered nurse using safe practice and good communication skills while attempting to coordinate care for this patient.

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(s) of 22 TEX. ADMIN. CODE

§217.11(1)(A),(1)(B),(1)(D),(1)(M),(1)(P)&(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 538230, heretofore issued to REBECCA ANN NIEMAN, 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 LIMITED LICENSE, 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) While under the terms of this Order, RESPONDENT SHALL NOT provide direct patient care. For the purposes of this Order, direct patient care involves a personal relationship between the Nurse and the client, and includes, but is not limited to: teaching, counseling, assessing the client's needs and strengths, and providing skilled nursing care.

(2) SHOULD RESPONDENT desire to return to a clinical practice setting, which would require her to provide direct patient care, RESPONDENT SHALL petition the Board for such approval, at which time, the RESPONDENT MUST satisfy all then existing requirements for re-issuance of the privilege to provide direct patient care. Further, the Board may impose reasonable conditions that must be satisfied by the RESPONDENT before re-issuance of an unencumbered license.

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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 violation(s) 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 18 day of July, 2013.

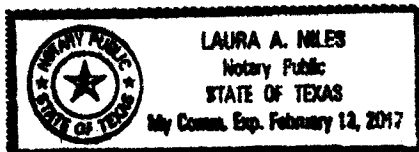
Rebecca Ann Nieman
REBECCA ANN NIEMAN, Respondent

Sworn to and subscribed before me this 18 day of July, 2013.

SEAL

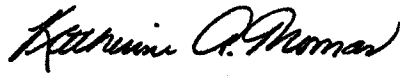
Laura A. Miles

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 18th day of July, 2013, by REBECCA ANN NIEMAN, Registered Nurse License Number 538230, and said Order is final.

Effective this 6th day of August, 2013.



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