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

DOCKET NUMBER 507-13-2117

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 300469	**§**	**OF**
ISSUED TO	**§**	
KAREN JULIET WALKER	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: KAREN JULIET WALKER
C/O MARC MEYER, ATTORNEY
33300 EGYPT LANE, SUITE B-200
MAGNOLIA, TX 77354-2739

BETH BIERMAN
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 17-18, 2013, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the vocational nursing license of Karen Juliet Walker without changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD, as if fully set out and separately stated herein, without modification. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or conclusions of law[1], the Board agrees with the ALJ's recommendation that the appropriate

[1] The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation. As such, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The choice of penalty is vested in the agency, not in the courts. An agency has broad discretion in determining which

sanction in this matter is a Warning with Stipulations[2].

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 5 through 23 and Conclusions of Law Numbers 8 through 10, raises serious concerns about the Respondent's professional character and ability to practice nursing safely[3]. The Respondent exhibited extremely poor judgment by failing to recognize and maintain appropriate professional boundaries of the nurse/client relationship[4]. Further, Respondent engaged in intentional, dishonest conduct by falsifying her time cards and patient records[5]. Respondent's conduct caused harm to the patient because the patient lost her home health care provider and posed a risk of harm to the patient because another provider would have relied on the inaccurate medical record she created to treat the patient[6]. Further, there is insufficient evidence that Respondent takes full accountability for her actions or has learned from her past mistakes in a way that would assure the Board that future misconduct will not occur[7].

Therefore, after reviewing the aggravating and mitigating factors in this matter[8], the Board finds that, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e), the Respondent should be issued a Warning with Stipulations, as recommended by the ALJ.

IT IS THEREFORE ORDERED, that RESPONDENT SHALL receive the sanction of 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

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sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. See *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App. - Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App. - Austin 2005, pet. denied); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

[2] The Board agrees with the ALJ that, pursuant to the Board's Disciplinary Matrix, the Respondent's conduct warrants second tier, sanction level I sanctions for her violations of §301.452(b)(10) & (13). See page 12 of the PFD.

[3] See pages 11-12 of the PFD and adopted Findings of Fact Numbers 5-23.

[4] See pages 11-12 of the PFD and adopted Findings of Fact Numbers 5-23.

[5] See adopted Findings of Fact Numbers 11-15 and 17-19.

[6] See adopted Findings of Fact Numbers 20-21.

[7] See pages 11-12 of the PFD.

[8] The Board has reviewed the aggravating and mitigating factors in this case. Further, the Board notes that the Respondent presented no evidence of mitigation. As a result, the Board has determined that the aggravating factors warrant the sanction recommended by the ALJ and imposed by the Board. See pages 11-12 of the PFD.

Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER 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 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 ORDERED 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 <u>not</u> 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.texas.gov/disciplinaryaction/stipscourses.html.*

(2) 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. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in "Respecting Professional Boundaries," a 3.9 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 Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(4) 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.texas.gov/disciplinaryaction/stipscourses.html.*

(5) RESPONDENT SHALL pay an administrative reimbursement in the amount of eighty four ($84) dollars. RESPONDENT SHALL pay this administrative reimbursement within forty five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IT IS FURTHER ORDERED, 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(S) 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) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). 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(s). 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.

(7) 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.

(8) While under the terms of this Order, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational 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.

(9) 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 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 ORDERED, 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 may be eligible for nurse licensure compact privileges, if any.

Entered this 17th day of October, 2013.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-13-2117 (July 23, 2013).

Upload Date: 20130723132133 Account Number: 814 Upload Description: 13-2117PFD

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 23, 2013

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTERAGENCY

RE: Docket No. 507-13-2117; Texas Board of Nursing v. Karen Walker

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Beth Bierman

Beth Bierman
Administrative Law Judge

BB/ad
Enclosures
XC: Jena Abel, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
Marc Meyer, 33300 Egypt Lane, Suite B-200, Magnolia, TX 77354 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-13-2117

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
KAREN JULIET WALKER, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to sanction Karen Juliet Walker, a licensed vocational nurse (LVN), based on allegations that she failed to maintain professional boundaries, falsely documented work hours, and falsely documented a medical record while caring for a pediatric patient (Patient). The Administrative Law Judge (ALJ) recommends that Ms. Walker be issued a warning with stipulations.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

ALJ Beth Bierman convened the hearing on May 6, 2013, in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by Jena Abel, Assistant General Counsel. Ms. Walker was represented by attorney Marc Meyer. The record closed on May 24, 2013, with the filing of the final written closing argument.

Matters concerning notice and jurisdiction were not contested, and are set out in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

A. Staff's Allegations

Staff alleges in its First Amended Formal Charges that:

- On February 18, 2011, while employed with MGA Home Healthcare, Plano, Texas (MGA), and assigned to provide nursing care for Patient, Ms. Walker failed to maintain professional boundaries when she loaned money to Patient's mother.
  This conduct, Staff alleges, was likely to injure Patient in that boundary violations can cause delayed distress for the patient that may not be recognized or felt by the patient until harmful consequences occur.

- On February 19, 2011, while employed with MGA and assigned to provide nursing care for Patient, Ms. Walker falsely documented that she had arrived to work two hours earlier than her actual arrival time, in an attempt to seek repayment of the loan she had made to Patient's mother, by billing the agency for payment of two hours that she had not worked. Staff alleged this conduct was likely to defraud MGA of the money paid to Ms. Walker that she had not worked and resulted in an inaccurate medical record.

- On February 19, 2011, while employed with MGA and assigned to provide nursing care for Patient, Ms. Walker falsely documented in Patient's medical record a nursing assessment, which included Patient's vital signs, at 9:00 a.m. when Ms. Walker did not arrive at Patient's home until 11:00 a.m. Staff alleged this conduct resulted in an inaccurate medical record and exposed Patient unnecessarily to a risk of harm in that subsequent caregivers would rely on Ms. Walker's documentation to provide further care to Patient.

B. Applicable Law

Staff first urges that Ms. Walker is subject to disciplinary sanction because the alleged conduct constituted unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public.[1]

Board Rule § 217.12[2] sets forth specific examples of unprofessional conduct, including the following, cited to by Staff in this case:

- Violating professional boundaries[3] of the nurse/client relationship including but not limited to . . . financial exploitation of the client or the client's significant other(s);[4]

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[1] Tex. Occ. Code § 301.452(b)(10).

[2] 22 Tex. Admin. Code § 217.12.

- Improper management of client records;[5]
- Misappropriating, in connection with the practice of nursing, anything of value or benefit, including but not limited to, any property, real or personal of the client, employer, or any other person or entity, or failing to take precautions to prevent such misappropriation;[6] and
- Falsifying reports, client documentation, agency records or other documents.[7]

Staff also contends that Ms. Walker is subject to disciplinary sanction because the alleged conduct constituted a failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient or other person unnecessarily to risk of harm.[8] Board Rule § 217.11 establishes standards of nursing practice, including the following, cited to by Staff in this case:

- Know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;[9]
- Implement measures to promote a safe environment for clients and others;[10]
- Adequately and completely report and document: (i) the client's status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist, or podiatrist orders; (iv) administration of medications and treatments; (v) client

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[3] "Professional boundaries" are defined in Board Rule § 217.1(29) as:

> "The appropriate limits which should be established by the nurse in the nurse/client relationship due to the nurse's power and the patient's vulnerability. Refers to the provision of nursing services within the limits of the nurse/client relationship which promote the client's dignity, independence and best interests and refrain from inappropriate involvement in the client's personal relationships and/or the obtainment of the nurse's personal gain at the client's expense."

[4] 22 Tex. Admin. Code § 217.12(6)(D).

[5] 22 Tex. Admin. Code § 217.12(1)(C).

[6] 22 Tex. Admin. Code § 217.12(6)(G).

[7] 22 Tex. Admin. Code § 217.12(6)(A).

[8] Tex. Occ. Code § 301.452(b)(13).

[9] 22 Tex. Admin. Code § 217.11(1)(A).

[10] 22 Tex. Admin. Code § 217.11(1)(B).

responses; and (vi) contacts with other health care team members concerning significant events regarding client's status;[11]

- Know, recognize, and maintain professional boundaries of the nurse-client relationship;[12] and

- As a licensed vocational nurse, assist in the determination of predictable healthcare needs of clients within healthcare settings and: (A) . . . utilize a systematic approach to provide individualized, goal-directed nursing care by: (i) collecting data and performing focused nursing assessments; (ii) participating in the planning of nursing care needs for the client; (iii) participating in the development and modification of the comprehensive nursing care plan for assigned clients; (iv) implementing appropriate aspects of care with the LVN's scope of practice; and (v) assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs.[13]

If the Board determines that a licensee has committed an act or omission that would violate one of the above standards, the Board shall take one or more of the following actions: issuance of a written warning; administration of a public reprimand; limitation or restriction of the person's license; suspension of the license; revocation of the license; or assessment of a fine. The Board may probate any penalty imposed on a nurse.[14] Board Rule § 213.33, including the Board's Disciplinary Matrix, provides guidance in determining the appropriate sanction for a violation.[15]

C. Evidence and Argument

1. Overview of evidence

Staff offered fifteen exhibits, eleven of which were admitted.[16] These exhibits included, among others: Ms. Walker's license information with the Board,[17] Ms. Walker's response to the

[11] 22 Tex. Admin. Code § 217.11(1)(D).

[12] 22 Tex. Admin. Code § 217.11(1)(J).

[13] 22 Tex. Admin. Code § 217.11(2)(A).

[14] Tex. Occ. Code § 301.453(a), (c).

[15] 22 Tex. Admin. Code § 213.33.

formal charges,[18] personnel records from MGA concerning Ms. Walker,[19] medical records from MGA,[20] and costs sought by Staff for processing the case.[21] Staff called three witnesses: Keith Weiss, Account Manager for MGA; Cristina Ruiz, R.N, Director of Clinical Services for MGA; and Denise Benbo, R.N., an expert in nursing practice. Ms. Walker testified on her own behalf.

2. Background

Ms. Walker has been licensed as an LVN in Texas since 2011. In February 2011, Ms. Walker was employed by MGA as a home health nurse. She provided home health care for Patient.

Patient, an approximately fourteen-year-old female, lives at home with her mother. Patient is described in the medical records as a total care patient, dependent upon others to maintain her respiratory, neurological, physical and nutritional status. She receives all nutrition via a tube, is non-ambulatory, and dependent on all transfers and repositioning. Two other siblings live with Patient and her mother.

3. Testimony of MGA employees Mr. Weiss and Ms. Ruiz

Mr. Weiss has been the account manager for MGA for six years. As a part of his duties, he handles all non-clinical matters for MGA, including payroll, operations, and human resources. He recruited Ms. Walker for her position with MGA and managed her non-clinical employment matters. Ms. Ruiz is the Director of Clinical Services for the office. She supervises all clinical matters for MGA, including all nurses, and ensures that the nurses are following the patients'

[16] Staff's Exs. 1-9, 13 and 18. Ms. Walker objected to Staff's Exs. 14 through 17, which were not admitted.

[17] Staff's Ex. 1.

[18] Staff's Ex. 5.

[19] Staff's Exs. 6, 7.

[20] Staff's Ex. 8.

[21] Staff's Ex. 13.

plans of care, and complying with the Board's rules and regulations. She supervised Ms. Walker's clinical matters.

Mr. Weiss was on call during the weekend in question. The mother called MGA on Sunday, February 20, 2011, to report that Ms. Walker did not arrive to work until 11:00 a.m. on Saturday, February 19, 2011, and she did not want Ms. Walker to return to care for her daughter. Mr. Weiss contacted Ms. Walker on Sunday and told her not to report to Patient's home on Monday, but to come to the office instead.

Mr. Weiss and Ms. Ruiz reviewed the medical records filled out by Ms. Walker for February 18 and 19, 2011. The medical records for February 18, 2011, indicate that Ms. Walker arrived at work at 7:00 a.m. and left at 7:00 p.m., her normal shift hours for that day.[22]

The medical records for Saturday, February 19, 2011, indicate that Ms. Walker arrived at work at 9:00 a.m. and left at 9:00 p.m., her normal shift hours for that day. Ms. Walker also noted in the records that she assessed Patient at 9:00 a.m. and took vital signs. The records state that the mother administered medications to Patient at 8:30 a.m. and changed Patient.[23]

Mr. Weiss and Ms. Ruiz met with Ms. Walker on Monday, February 21, 2011. Susan Collier, MGA corporate Director of Clinical Services, was also at the meeting. During the meeting, Ms. Walker explained that while she was in the mother's car with the mother and Patient returning from Patient's doctor's visit, the mother's car overheated.[24] Ms. Walker did not want to be stranded, so she bought radiator fluid and some gas to get them back to Patient's home. Ms. Walker explained that she and the mother had agreed that she would come in two hours late in partial payment for the money Ms. Walker spent on their behalf.

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[22] Staff's Ex. 8 at 13. Ms. Walker later testified that she did not leave Patient's home until 1:30 a.m., February 19, 2011.

[23] Staff's Ex. 8 at 9.

[24] It is unclear exactly on which day this occurred. Ms. Walker testified that it was a couple of weeks before February 19, 2011.

Mr. Weiss testified that he remembered the amount loaned by Ms. Walker to the mother was approximately $70. He explained that MGA has a policy that nurses do not loan money to patients because it would open the door for bigger boundaries to be crossed in the nurse/patient relationship.

MGA also has a policy about not falsifying time cards.[25] Mr. Weiss explained that the nurse writes in the nursing note the patient's medical assessments and the time worked by the nurse. Both the nurse and the patient's guardian sign the nursing note.[26] The nursing notes for the week are turned in every Sunday for payment to the nurse and for Medicaid billing purposes. Because the mother called and told MGA that Ms. Walker had submitted the incorrect time worked for February 19, 2011, MGA was able to correct the time before submitting it for payment to the state Medicaid system. He testified that Medicaid fraud occurs if incorrect billing is submitted for payment to the state Medicaid system.

Mr. Weiss testified that it was not until after the meeting with Ms. Walker that MGA had learned that Ms. Walker had taken Patient to her home after her shift on February 18, 2011. As will be discussed further below, Patient's mother did not return to the home at the expected time on February 18th, and Ms. Walker subsequently took Patient and Patient's siblings to her home. According to Mr. Weiss, MGA would not allow a nurse to take a patient out of the patient's home unless the patient's safety was in danger. At a minimum, he believed the nurse should call the office before doing so. In his opinion, an LVN cannot make the decision on her own to remove a patient from their home.

Ms. Ruiz echoed Mr. Weiss' testimony regarding the inappropriateness of taking a patient home. According to Ms. Ruiz, the nurse must document everything that goes on during a shift, including the time spent with a patient. In her opinion, this would include documenting that Patient was at Ms. Walker's home. Ms. Ruiz testified if a situation arises that a parent or guardian does not return at the expected time, the nurse is expected to call the office and MGA

[25] Staff's Ex. 7 at 11. Ms. Walker signed the employment agreement.

[26] Staff's Ex. 8 at 10.

will arrange for an alternate caregiver. Ms. Ruiz testified that she thought Ms. Walker had loaned approximately $60 to the mother. Although MGA asked for a receipt, it never received one.

During the meeting, Ms. Walker signed an Employee Counseling Record[27] and was thereafter terminated by MGA. MGA also terminated home health care service to Patient after a seven-day grace period.

4. Testimony of Denise Benbo, R.N.

Ms. Benbo, R.N., has been a nursing practice consultant with the Board since August 2007. She also works as a staff nurse on the cardiac care floor for Seton Hospital, Austin, Texas.[28]

Ms. Benbo testified that the Board is concerned about ~~maintaining professional~~ boundaries because, in general, patients are vulnerable. The nurse has access to all of the patient's medical and personal information, and is the conduit to the rest of the patient's health care team. The nurse, therefore, has the power in the nurse/patient relationship. Ms. Benbo explained that when there is an exchange of money outside the health care relationship, it may impact the patient's care and affect the amount of power the nurse has in the relationship. The exchange of money keeps the patient reliant on the nurse, and changes the dynamic of the relationship. Instead of loaning money to the patient or the patient's family, Ms. Benbo contended the nurse should connect the patient with appropriate community resources. Ms. Benbo testified that a nurse must honor professional boundaries and to not do so would constitute unprofessional conduct under the Board's rules.

With regard to documentation, Ms. Benbo testified that nurses must accurately document what happens with a patient, including but not limited to patient care, status, signs and systems,

[27] Staff's Ex. 8 at 3.

[28] Staff's Ex. 9.

medications, treatments, patient responses, and contacts with other care providers. A nurse must not falsify documents or records because any inaccuracies may affect patient care.[29] Other care providers would rely on the nurse's inaccurate documentation in providing further care. Inaccurate documentation also creates the potential for billing fraud. And although false billing information was not submitted for payment in this case, Ms. Benbo believed that Ms. Walker's inaccurate documentation could have affected Patient's care by depriving Patient of the care she needed. Because MGA terminated service to Patient, Ms. Benbo believed Patient suffered actual harm through the loss of her home health provider as a result of Ms. Walker's conduct.

As to the proper sanction, Ms. Benbo testified that, according to the Board's Disciplinary Matrix, both the unprofessional conduct[30] and the failure to conform to the minimum standards of acceptable nursing practice[31] violations were second-tier offenses. In her opinion, Ms. Walker's unprofessional conduct and failure to conform to the minimum standards of practice subjected Patient to actual harm or risk of harm, and violated the boundaries of the nurse/patient relationship.

Ms. Benbo identified several aggravating circumstances applicable to this case, including the loss of Patient's home health care service, the risk of harm with the increase in vulnerability to Patient when the professional boundary was breached, and the risk of harm to Patient as a result of Ms. Walker's incorrect documentation on the medical and time records. She identified no mitigating circumstances. In her opinion, Ms. Walker admitted the violations only when confronted. Therefore, she regards Ms. Walker's violations as being second-tier, sanction level I offenses. She recommends a warning with stipulations, as well as requirements that Ms. Walker take courses in nurse jurisprudence, ethics, professional boundaries, documentation, and critical thinking. She recommends that, for a period of one year, Ms. Walker be required to notify her employer of the Board order, that her employer submit quarterly reports to the Board regarding Ms. Walker's progress, and that Ms. Walker's nursing practice be indirectly supervised.

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[29] Ms. Benbo questioned whether the assessment of Patient documented as having occurred at 9:00 a.m., February 19, 2011, actually occurred.

[30] Tex. Occ. Code § 301.452(b)(10).

[31] Tex. Occ. Code § 301.452(b)(13).

5. Ms. Walker's Testimony and Argument

Ms. Walker testified she loaned money to Patient's mother when the car overheated, but contended the amount was only $20. She admitted she submitted a time report to MGA for February 19, 2011, that indicated she arrived at Patient's home at 9:00 a.m., when in fact she did not arrive until 11:00 a.m. She admitted that she and the mother agreed that Ms. Walker would arrive two hours late that day in partial repayment of the money loaned to fix the car. Ms. Walker contended she did assess Patient and take Patient's vital signs at 9:00 a.m., as she had indicated in the nursing note, and contended the assessment occurred at her home. She could not explain her notation that the mother had administered medications and changed Patient at 8:30 a.m., given that Ms. Walker and Patient did not arrive at Patient's home until 11:00 a.m.

Ms. Walker explained the circumstances leading to her taking Patient and the siblings to her home after her shift on February 18, 2011. The mother's husband had previously been removed from the home. Ms. Walker was scheduled to work 9:00 a.m. to 9:00 p.m. that day; however, she agreed with Patient's mother to stay an extra three hours, until midnight, so that the mother could spend time with her husband. At midnight, the mother had not returned. Ms. Walker called the mother's cell phone and the husband's cell phone, but neither answered. The mother never called Ms. Walker that night. Ms. Walker testified that she was tired and hungry, so at 1:30 a.m. she took Patient and the siblings to her home. She did not call MGA to report that the mother had not returned home, nor did she report that she was taking Patient and the siblings to her home.

Ms. Walker testified she was very upset with the mother and that the next day they had a "screaming" argument in which Ms. Walker told the mother that the mother could not take her for granted. The day after the argument, the mother contacted MGA and told MGA that Ms. Walker had submitted the incorrect number of hours, and requested that Ms. Walker not return to provide care for Patient.

Ms. Walker testified that she allowed her "humanness" to overcome her professional responsibilities. She contended, however, that it was reasonable for her to spend the money for radiator fluid and gas so that they were not stranded in the mother's car. She agreed that she had placed herself in a difficult situation by allowing the mother extra hours to spend with her husband. She contended, however, that she was able to care for Patient in her own home without the medical equipment located at Patient's home.

D. ALJ's Analysis and Recommendation

Ms. Walker admitted she loaned money to Patient's mother, admitted she submitted a false time report, admitted she and Patient's mother entered into an agreement to submit a false time report as partial repayment of money Ms. Walker loaned to Patient's mother, and admitted that the assessment of Patient documented at 9:00 a.m., February 19, 2011, occurred at her home. She did not explain why she documented that the mother gave medications and changed Patient at 8:30 a.m. that day when she admitted that she did not arrive at Patient's home with Patient until 11:00 a.m. Ms. Walker's only defense or argument appears to be that these actions—loaning money, submitting false time sheets, and submitting false medical documentation—are somehow *de minimis* and therefore do not rise to the level of violations of the Board's rules such that she should be sanctioned. The ALJ disagrees.

It is clear from the evidence that Ms. Walker violated the boundaries of the nurse/patient relationship, submitted false time reports to MGA, and submitted incorrect medical records for Patient as charged by Staff. Based on this evidence, the ALJ concludes that Ms. Walker failed to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice. Ms. Walker's conduct also constituted unprofessional conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public. Her conduct subjects her to sanctions pursuant to Texas Occupations Code §§ 301.452(b)(10) and (13) and Board Rules §§ 217.11(1)(A), (1)(B), (1)(D), (1)(J), (2)(A) and 217.12(1)(C), (6)(A), (6)(D), (6)(G).

Based on the evidence, Ms. Walker's conduct constituted second-tier violations of Texas Occupations Code § 301.452(b)(10) and (13). The Board's Disciplinary Matrix requires an examination of aggravating and mitigating factors to determine which sanction level is warranted. Ms. Benbo correctly identified applicable aggravating circumstances, including the actual risk to Patient of losing her home health care provider, the risk to Patient given that the medical documentation was falsified, and the risk to Patient given the violation of professional boundaries. While Ms. Benbo identified several aggravating circumstances, no applicable mitigating factors were presented by Ms. Walker. Therefore, Ms. Walker's actions warrant sanctions for second-tier violations of Texas Occupations Code §§ 301.452(b)(10) and (13), sanction level I.

The ALJ recommends that Ms. Walker be issued a warning with stipulations that she be required to successfully complete remedial education as specified by the Board; that she be required to notify employers of the Board order; that her practice be indirectly supervised; and that her employers be required to submit quarterly reports. Finally, the ALJ recommends that Staff recover the requested $84 in processing costs associated with this case.

III. FINDINGS OF FACT

1. Karen Juliet Walker is licensed as a vocational nurse (LVN) by the Texas Board of Nursing (Board).

2. On February 7, 2013, the Board's staff (Staff) mailed its First Amended Notice of Hearing to Ms. Walker.

3. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

4. The hearing convened May 6, 2013, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Staff was represented by Jena Abel, Assistant General Counsel. Ms. Walker was represented by attorney Marc Meyer. The record closed on May 24, 2013, with the filing of the final written closing argument.

5. In February 2011, Ms. Walker was employed by MGA Home Healthcare (MGA) as a home health nurse.

6. Ms. Walker provided home health care for an approximately fourteen-year-old female (Patient), who lived at home with her mother. Patient is a total care patient, dependent upon others to maintain her respiratory, neurological, physical and nutritional status. She receives all nutrition via a tube, is non-ambulatory, and is dependent on all transfers and repositioning. Two other siblings live with Patient and her mother.

7. Although the medical records for February 18, 2011, state that Ms. Walker arrived at Patient's home for work at 7:00 a.m. and left at 7:00 p.m., her normal shift hours for that day, she actually stayed at Patient's home until 1:30 a.m., February 19, 2011, waiting for Patient's mother to return.

8. Ms. Walker had agreed with Patient's mother that Ms. Walker would stay late on February 18, 2011, so that Patient's mother could spend time with her husband, who had been excluded from the home.

9. Ms. Walker attempted to contact the mother and the mother's husband by cell phone at midnight, February 18, 2011, when the mother had not returned at the agreed upon time. Neither the mother nor the husband answered their phones, and the mother did not call Ms. Walker that night.

10. At 1:30 a.m., February 19, 2011, Ms. Walker left Patient's home with Patient and Patient's siblings and took the children to her home.

11. The medical records for February 19, 2011, state that Ms. Walker arrived at work at 9:00 a.m. and left at 9:00 p.m., her normal shift hours for that day, although Ms. Walker did not arrive at Patient's home with Patient and Patient's siblings until 11:00 a.m.

12. The medical records for February 19, 2011, state that Ms. Walker assessed Patient at 9:00 a.m. and took vital signs. The records also state that Patient's mother administered medications to Patient at 8:30 a.m. and changed Patient.

13. Patient's mother reported to MGA that Ms. Walker submitted incorrect work hours for February 19, 2011. Patient's mother requested that Ms. Walker not return to care for Patient.

14. On or about February 18, 2011, Ms. Walker was with Patient in Patient's mother's car when it overheated. Ms. Walker loaned money to Patient's mother for radiator fluid and gas.

15. Ms. Walker and Patient's mother agreed that Ms. Walker could arrive two hours late to Patient's home on February 19, 2011, as partial repayment of the money loaned to Patient's mother.

16. MGA terminated Ms. Walker's employment on February 21, 2011, and later terminated home health service to Patient.

17. MGA was able to correct Ms. Walker's time for February 19, 2011, before the time was submitted for payment to the state Medicaid system.

18. Ms. Walker submitted a false time report for her work on February 19, 2011.

19. Ms. Walker submitted a false medical record for Patient on February 19, 2011.

20. Patient suffered harm as a result of Ms. Walker's conduct because Patient lost her home health care provider.

21. Patient was at risk of harm because of Ms. Walker's conduct because another care provider would have relied on the inaccurate medical record to treat Patient.

22. Ms. Walker failed to maintain the professional boundaries of the nurse-client relationship.

23. Patient was at risk of harm because of Ms. Walker's failure to maintain the professional boundaries of the nurse-client relationship.

IV. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. Tex. Occ. Code ch. 301.

2. The State Office of Administrative Hearings (SOAH) has jurisdiction over the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Gov't Code ch. 2003.

3. Proper and timely notice of the hearing was provided. Tex. Gov't Code ch. 2001.

4. A nurse is subject to discipline for unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public. Tex. Occ. Code § 301.452(b)(10).

5. "Unprofessional conduct" includes:

   - Violating professional boundaries of the nurse/client relationship including but not limited to . . . financial exploitation of the client or the client's significant other(s). 22 Tex. Admin. Code § 217.12(6)(D).
   - Improper management of client records. 22 Tex. Admin. Code § 217.12(1)(C).

- Misappropriating, in connection with the practice of nursing, anything of value or benefit, including but not limited to, any property, real or personal of the client, employer, or any other person or entity, or failing to take precautions to prevent such misappropriation. 22 Tex. Admin. Code § 217.12(6)(G).

- Falsifying reports, client documentation, agency records or other documents. 22 Tex. Admin. Code § 217.12(6)(A).

6. A nurse is subject to discipline for failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm. Tex. Occ. Code § 301.452(b)(13).

7. Standards of nursing practice include:

- Know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice. 22 Tex. Admin. Code § 217.11(1)(A).

- Implement measures to promote a safe environment for clients and others. 22 Tex. Admin. Code § 217.11(1)(B).

- Adequately and completely report and document: (i) the client's status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist, or podiatrist orders; (iv) administration of medications and treatments; (v) client responses; and (vi) contacts with other health care team members concerning significant events regarding client's status. 22 Tex. Admin. Code § 217.11(1)(D).

- Know, recognize, and maintain professional boundaries of the nurse-client relationship. 22 Tex. Admin. Code § 217.11(1)(J).

- As a licensed vocational nurse, assist in the determination of predictable healthcare needs of clients within healthcare settings and: (A) . . . utilize a systematic approach to provide individualized, goal-directed nursing care by: (i) collecting data and performing focused nursing assessments; (ii) participating in the planning of nursing care needs for the client; (iii) participating in the development and modification of the comprehensive nursing care plan for assigned clients; (iv) implementing appropriate aspects of care with the LVN's scope of practice; and (v) assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs. 22 Tex. Admin. Code § 217.11(2)(A).

8. Ms. Walker engaged in unprofessional conduct by violating the professional boundary between herself and Patient's mother, by falsifying a time report, and by falsifying a medical record. Tex. Occ. Code § 301.452(b)(10).

9. Ms. Walker failed to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice by failing to conform to the Board's rules, by failing to maintain the professional boundary, and by failing to adequately and appropriately document Patient's status, thereby exposing Patient unnecessarily to the risk of harm to her health. Tex. Occ. Code § 301.452(b)(13).

10. Ms. Walker's conduct subjects her to sanctions pursuant to Texas Occupations Code § 301.452(b)(10) and (13) and 22 Texas Administrative Code §§ 217.11(1)(A), (1)(B), (1)(D), (1)(J), (2)(A) and 217.12(1)(C), (6)(A), (6)(D), (6)(G).

11. If the Board determines that a licensee has committed an act that subjects the nurse to sanction, the Board shall take one or more of the following actions: issuance of a written warning; administration of a public reprimand; limitation or restriction of the person's license; suspension of the license; revocation of the license; or assessment of a fine. Tex. Occ. Code § 301.453.

12. The Board's Disciplinary Matrix, 22 Texas Administrative Code § 213.33(b), provides guidance in determining the appropriate sanction for a violation.

13. The Board's rules specify factors to be used in disciplinary matters. 22 Tex. Admin. Code § 213.33(c).

V. RECOMMENDATION

The ALJ recommends that Ms. Walker be issued a warning with stipulations that she be required to successfully complete remedial education as specified by the Board; that she be required to notify employers of the Board order; that her practice be indirectly supervised; and that her employers be required to submit quarterly reports. Finally, the ALJ recommends that Staff recover the requested $84 in processing costs associated with this case.

SIGNED July 23, 2013.

Beth Bierman

BETH BIERMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS