BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Vocational Nurse License Number 214669	§	
issued to HEATHER LILLIAN FEDRIC	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of HEATHER LILLIAN FEDRIC, Vocational Nurse License Number 214669, 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) and 301.453, 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 June 9, 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 vocational nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Clarendon College, Clarendon, Texas, on December 6, 2007. Respondent was licensed to practice vocational nursing in the State of Texas on February 12, 2008.

5. Respondent's nursing employment history includes:

2008-2009	Charge Nurse	Heritage Convalescent Center Amarillo, Texas
1/2009-6/2009	Charge Nurse	Community Care Center of Clarendon Clarendon, Texas

Respondent's nursing employment history continued:

6/2009-7/2010	ADON	Community Care Center of Clarendon Clarendon, Texas
7/2010-1/2012	Staff Nurse	Collingsworth General Hospital Wellington, Texas
8/2011-1/2012	Agency Nurse	Nursefinders Amarillo Amarillo, Texas
2/2012-Present	Unknown	Unknown

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, and had been in this position for six (6) months.

7. On or about January 28, 2011 and January 29, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer the evening dose of Rocephin 250 milligrams to Patient Number 100596, which was ordered to be given twice a day. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's bacterial infection.

8. On or about February 4, 2011, February 5, 2011 and February 6, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent continued to administer Mucomyst to Patient Number 100813 six (6) times after the medication had been discontinued. Respondent's conduct exposed the patient to risk of harm from unnecessary administration of extra doses of medication without a physician's order.

9. On or about February 14, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to accurately and completely transcribe a physician's order for Reglan and Carafate for Patient Number 101188. The physician had ordered each medication to be given before meals and at bedtime; Respondent failed to transcribe the bedtime dose. Respondent's conduct resulted in an inaccurate, incomplete medical record, and exposed the patient to risk of harm in that subsequent care givers would rely on her documentation in order to provide further patient care.

10. On or about February 14, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer Reglan 10 milligrams and Carafate 1 gram to the aforementioned Patient Number 101188 at bedtime, as ordered. Respondent's conduct was likely to injure the patient in that the omission placed the patient at risk of ineffective treatment which could result in a delay in the patient's recovery.

11. On or about February 20, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent erroneously transcribed a physician's order for Pepcid 20 milligrams intravenous (IV) twice a day as Pepcid 20 mg IV before meals and at bedtime for Patient Number 101484. Respondent's conduct resulted in an inaccurate, incomplete medical record, and exposed the patient to risk of harm in that subsequent care givers would rely on her documentation in order to provide further patient care.

12. On or about March 25, 2011, March 26, 2011, March 31, 2011 and April 1, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer the evening doses of Metoprolol 25 milligrams to Patient Number 103420, which was ordered to be given twice a day. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's hypertension.

13. On or about March 31, 2011, April 1, 2011, and April 3, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer Zosyn 3.375 grams every six (6) hours to Patient Number103749, as ordered. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's bacterial infection.

14. On or about May 24, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent erroneously transcribed the physician's order for Zosyn 3.375 grams as Zosyn 3.375 milligrams for Patient Number 105970. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to risk of harm in that subsequent care givers would rely on her documentation in order to provide further patient care.

15. On or about June 3, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent administered two (2) doses of Florinef 0.1 milligrams to Patient Number 106332, instead of once daily as ordered. Respondent's conduct was likely to injure the patient from adverse effects due to possible over dosage of medication.

16. On or about June 4, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer Tygacil 50 milligrams IV to Patient Number 106598, as ordered. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's bacterial infection.

17. On or about June 5, 2011 and June 6, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer the evening doses of Metoprolol 50 milligrams to Patient Number 106668, which was ordered to be given twice a day. Respondent's conduct was likely to injure the patient in that failure

to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's hypertension.

18. On or about July 1, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer Solu-Medrol 60 milligrams IV to Patient Number107770, as ordered. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.

19. On or about August 12, 2011, while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent falsely or erroneously documented in the Medical Record of Patient Number 109390 that she administered Lyrica 150 milligrams to the patient. Recordings in the medication dispensing machine indicated that no Lyrica had been removed for the patient. Respondent's conduct resulted in an inaccurate medical record and exposed the patient to risk of harm in that subsequent care givers would rely on her documentation in order to provide further patient care and was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's pain.

20. On or about December 7, 2011 and December 8, 2011 while employed as a Staff Nurse with Collingsworth General Hospital, Wellington, Texas, Respondent failed to administer the evening doses of Sotalol 40 milligrams to Patient Number 114246, which was ordered to be given twice a day. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.

21. In response to the incidents in Findings of Fact Numbers Seven (7) through Twenty (20), Respondent states in general that most of the incidents were transcription errors, which were due to the fact that at Collingsworth General Hospital, the Licensed Vocational Nurses wrote the Medication Administration Records (MAR) by hand, and were solely responsible for what was transcribed. Respondent states that due to multiple errors by the LVNs, a new policy was implemented that required two licensed nurses to confirm and initial each transcription on the MAR. Further, at shift change the oncoming shift is also responsible for checking new orders and ensuring that all transcriptions are correct. Respondent states that by following the new policies she hopes to avoid subsequent transcription errors. In response to Finding of Fact Sixteen (16) specifically, Respondent states that she was unable to administer the medication because new trauma patients to the emergency room kept her off the unit.

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)(B),(1)(C)&(1)(D) and 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 Vocational Nurse License Number 214669, heretofore issued to HEATHER LILLIAN FEDRIC, 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 WARNING WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

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

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

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

complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic

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

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation.

RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR(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:

(5) 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.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL be supervised by a Registered Nurse, 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.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the 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(s) of employment as a nurse.

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

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the 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 10 day of Sept, 2013.

Heather Lillian Fedric

HEATHER LILLIAN FEDRIC, RESPONDENT

Sworn to and subscribed before me this 10th day of September, 2013.

SEAL

LUCHERYL SPEED
MY COMMISSION EXPIRES
April 10, 2016

Lucheryl Speed

Notary Public in and for the State of Hall, Texas

SEP 13 2013

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 10th day of September, 2013, by HEATHER LILLIAN FEDRIC, Vocational Nurse License Number 214669, and said Order is final.

Effective this 17th day of October, 2013.

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