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 507-13-5432

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 214369	§	
ISSUED TO	§	**OF**
CHRISTINE DENISE	§	
(MCFATHER) WINDOM	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: CHRISTINE DENISE (MCFATHER) WINDOM
5704 VISTA PARK LANE
SACHSE, TEXAS 7 5048

JOANNE SUMMERHAYS
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 23-24, 2014, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's exceptions to the PFD; (3) the Respondent's response letter; (4) the ALJ's final letter ruling of December 12, 2013; (5) Staff's recommendation that the Board adopt the PFD regarding the vocational nursing license of Christine Denise (McFather) Windom without changes; and (6) 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. Staff filed exceptions to the PFD on November 22, 2013. The Respondent filed a response to the PFD and Staff's exceptions to the PFD on December 27, 2013. On December 12, 2013, the ALJ issued her final letter ruling, in which she amended Finding of Fact Number 8. The ALJ declined to make any other changes to the PFD, including her recommended sanction.

The Board, after review and due consideration of the PFD; Staff's exceptions to the PFD; the Respondent's response to the PFD and Staff's exceptions to the PFD; the ALJ's final letter ruling of December 12, 2013; 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, including amended Finding of Fact Number 8, as set out in the ALJ's final letter ruling of December 12, 2013, 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 sanction in this matter is Remedial Education with a Fine.[2]

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 14-21 and Conclusions of Law Numbers 9 and 10, raises some concern about the Respondent's ability to practice nursing safely in the future. The Respondent's failure to document the administration of a highly abused opiate analgesic in a patient's medical record posed a risk of harm to the patient[3]. However, the Respondent presented significant mitigating evidence during the hearing. The Respondent has no prior disciplinary history. No actual harm to the patient was shown[4]. System dynamics in the practice setting may have contributed to the Respondent's error[5]. Further, the Respondent provided written letters of recommendation from other professionals, as well as certificates of completion for 14 continuing education courses completed within the last two years[6].

The Board has reviewed these mitigating factors in determining the appropriate sanction in this case. After reviewing the aggravating and mitigating factors in this case, 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), (f), and (g), that Remedial Education and a Fine should be imposed against the Respondent's license.

IT IS THEREFORE ORDERED, that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION AND A FINE 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.

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[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 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 the Respondent's conduct warrants a first tier, sanction level I sanction for her violations of §301.452(b)(10) and (13). See page 26 of the PFD.

[3] See adopted Findings of Fact Numbers 14-21 and adopted Conclusion of Law Number 9.

[4] See adopted Finding of Fact Number 24.

[5] See adopted Finding of Fact Number 25.

[6] See adopted Finding of Fact Number 28.

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 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 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.*

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

(4) RESPONDENT SHALL pay a monetary fine in the amount of two hundred and fifty dollars ($250) dollars. RESPONDENT SHALL pay this monetary fine 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, 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 23rd day of January, 2014.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-13-5432 (November 5, 2013).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

November 5, 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. 507-13-5432; Texas Board of Nursing v. Christine Denise Windom

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,

Joanne Summerhays
Administrative Law Judge

JS/mle
Enclosures
XC: John F. Legris, 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 (with 1 CD) – **VIA INTERAGENCY**
Christine D. Windom, LVN, 5704 Vista Park Lane, Sachse, TX 75048 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-13-5432

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
CHRISTINE DENISE WINDOM, Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-13-5432

TEXAS BOARD OF NURSING, Petitioner	§ §	BEFORE THE STATE OFFICE
v.	§ §	OF
CHRISTINE DENISE WINDOM, Respondent	§ §	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to sanction Christine Denise Windom,[1] a licensed vocational nurse (LVN), based on allegations that she administered a drug to a patient without a physician's order, failed to properly document the administration of a drug, failed to follow a facility policy and procedure for wastage of an unused drug, and misappropriated a drug or failed to take precautions to prevent such misappropriation. The Administrative Law Judge (ALJ) finds that the Staff proved its allegations regarding failure to properly document the administration of a drug, but did not prove its allegations of administration of a medication without doctor's orders, failure to follow a facility policy regarding wastage, or misappropriation or failure to take precautions to prevent misappropriation. The ALJ recommends that Ms. Windom be required to complete remedial education specified by the Board and pay a fine of $250.00.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

ALJ Joanne Summerhays convened the hearing on September 10, 2013, in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by John F. Legris, Assistant General Counsel. Ms. Windom appeared and represented herself. The

[1] At the time of the events at issue in this case, Ms. Windom's name was Christine McFather. The documents admitted into evidence reflect her name at the time of the events at issue.

record closed on the same date.[2] 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 that Ms. Windom is subject to disciplinary sanction because she engaged in unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public[3] and failed 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.[4] Specifically, Staff alleges that on September 25, 2011, while employed with AMN Healthcare/Nursefinders, in San Diego, California (the Agency), and assigned to Plum Creek Specialty Hospital, in Amarillo, Texas (the Facility), Ms. Windom:

- administered a medication, Fentanyl, to a patient (Patient 536)[5] without a physician's order;
- failed to record the administration of Fentanyl to Patient 536 on the medication administration record (MAR) and/or in the Nurses Notes;
- administered Fentanyl to another patient (Patient 608) and failed to document the administration on the MAR and/or in the Nurses Notes;
- withdrew Fentanyl for Patients 608 and 536, failed to administer it, and failed to follow the Facility's policy and procedure for wastage of unused portions of the medication; and

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[2] The ALJ issued Order No. 2 informing the parties that the portion of the hearing which occurred after the lunch break, consisting of Staff's second cross-examination of Ms. Windom and rebuttal testimony by Staff's expert, Ms. Hester, was inadvertently not recorded. The ALJ provided the parties with the options of reopening the record or letting the current record stand without the unrecorded portion. On October 9, 2013, Staff filed a response asking that the record stand as it currently exists without the unrecorded portions. Ms. Windom did not file a response. The ALJ will consider the record as it stands without the unrecorded portion.

[3] Tex. Occ. Code § 301.452(b)(10).

[4] Tex. Occ. Code § 301.452(b)(13).

[5] For purpose of protecting the identity of the patients involved in the events giving rise to this case, this Proposal for Decision uses "Patient" and the last three digits of the Patient's Medical Record number as shown on the Patient's records in evidence, in place of the Patient's name.

- misappropriated Fentanyl belonging to the Facility or the Patients or failed to take precautions to prevent such misappropriations.

B. Applicable Law

A licensed nurse is subject to disciplinary sanctions if the nurse engages in unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public.[6] The Board's rules further define dishonorable conduct to include the following conduct cited by Staff in this case:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11;[7]
- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[8]
- Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established;[9]
- Falsification of or making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances;[10]
- Failing to follow the policy and procedure in place for the wastage of medications at the facility where the nurse was employed or working at the time of the incident(s);[11]
- Violating an order of the board, or carelessly or repetitively violating a state or federal law relating to the practice of vocational, registered or advanced practice nursing, or violating a state or federal narcotics or controlled substance law;[12]

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[6] Tex. Occ. Code § 301.452(b)(10).

[7] 22 Tex. Admin. Code § 217.12(1)(A).

[8] 22 Tex. Admin. Code § 217.12(1)(B).

[9] 22 Tex. Admin. Code § 217.12(4).

[10] 22 Tex. Admin. Code § 217.12(10)(B).

[11] 22 Tex. Admin. Code § 217.12(10)(C).

[12] 22 Tex. Admin. Code § 217.12(11)(B).

- 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;[13] and
- Diversion or attempts to divert drugs or controlled substances.[14]

A nurse is also subject to disciplinary sanctions if the nurse fails 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.[15] The Board's rules establish the minimum acceptable standards of nursing practice, including the following requirements cited 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;[16]
- Implement measures to promote a safe environment for clients and others;[17] and
- Accurately 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 response(s); and
  (vi) contacts with other health care team members concerning significant events regarding client's status.[18]

If the Board determines that a licensee has committed a sanctionable act or omission under 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

[13] 22 Tex. Admin. Code § 217.12(6)(G).

[14] 22 Tex. Admin Code § 217.12(8).

[15] Tex. Occ. Code § 301.452(b)(13).

[16] 22 Tex. Admin. Code § 217.11(1)(A).

[17] 22 Tex. Admin. Code § 217.11(1)(B).

[18] 22 Tex. Admin. Code § 217.11(1)(D).

fine.[19] The Board may probate any penalty imposed on a nurse.[20] Board Rule 213.33 includes the Board's Disciplinary Matrix.[21] The Disciplinary Matrix classifies violations of Board rules into three tiers based on the severity of the violation. Each tier is further divided into two levels of sanctions. In addition, the Board has adopted multiple mitigating and aggravating factors for the Board to consider in determining the appropriate sanction.[22]

C. Undisputed Background Facts

Ms. Windom has been licensed as an LVN in Texas since 2008.[23] In 2011, she accepted a job working as an agency nurse with the Agency, which assigned her to work in facilities needing a nurse for one or more shifts on a temporary basis. For her first assignment, she was sent to work at the Facility for the 7:00 a.m. to 7:00 p.m. shift on September 25, 2011.

Patient 536 was an 82-year-old female who was admitted to the Facility on Friday, September 23, 2011, with a decubitis ulcer on her coccyx. She was admitted for long-term acute care with intravenous (IV) antibiotics and physical therapy.[24] On admission, she was ordered to be placed on a Patient Controlled Analgesia (PCA) pump for pain, with 10 mcg(micrograms)/ML(milliliter) of Fentanyl by IV, maximum 75 mcg per hour.[25] On September 24, 2011, the order was discontinued because the tubing for the PCA pump was unavailable. An order for Lortab by mouth as needed for pain was substituted.[26] The Lortab

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[19] Tex. Occ. Code § 301.453(a).

[20] Tex. Occ. Code § 301.453(c).

[21] 22 Tex. Admin. Code § 213.33. The Disciplinary Matrix is found as an attached graphic at 22 Tex. Admin. Code § 213.33(b).

[22] 22 TAC § 213.33(c). The Disciplinary Matrix also sets out additional mitigating and aggravating factors.

[23] Staff Ex. 1 (Board computer licensure record for Ms. Windom).

[24] Staff Ex. 9 (Facility medical records) at 66.

[25] Staff Ex. 9 at 68, 93.

[26] Staff Ex. 9 at 80. The reason for the discontinuation of the order—missing hose—was not found in the medical records, but in a document titled, "Detailed investigation of incident involving one PCA fentanyl and two fentanyl 50 mcg/mL vials" in the Agency's records. Staff Ex. 7 (Agency Departmental records) at 4. The author of the document stated in the document that she was employed by Omnicare/Pharmasource as the Pharmacist in Charge (PIC) at the Facility shortly after the incident, but she was not employed at the time of the incident. The author does not indicate where she got the information in the document. She also stated in the document that the on-call pharmacist at the time of the incident was no longer employed by her company.

order was discontinued that same date because the Patient was allergic to it.[27] A new order for "Fentanyl 25 mcg by IV P [push]" every 4 hours as needed was entered on Monday, September 26, 2013.[28] On Sunday, September 25, 2011, when Ms. Windom was assigned to work at the Facility, there was no other order for pain medication for Patient 536 in the record.

Patient 608 was a 76-year-old female who was admitted to the Facility on September 16, 2011, for long-term treatment following a bowel resection and colostomy. On admission, she had two orders for Fentanyl as follows:

> FENTANYL VL 25 MCG FENTANYL CIT [CITRATE] IV 0.5 ML x 50 MCG/ML EVERY TWO HOURS CAUTION: HIGH ALERT/HIGH RISK DRUG PUSH UNDILUTED OVER 1 TO 2 MINUTES PRN [AS NEEDED] PAIN
>
> FENTANYL VL 50 MCG FENTANYL CIT IV 1 ML x 50 MCG/ML PRN EVERY TWO HOURS CAUTION: HIGH ALERT/HIGH RISK DRUG PUSH UNDILUTED OVER 1 TO 2 MINUTES PRN PAIN[29]

D. Evidence and Analysis

1. Overview of evidence

Staff offered twelve exhibits, all of which were admitted.[30] These exhibits included, among others: Ms. Windom's license information with the Board,[31] personnel records and policy and procedure records from the Agency,[32] pharmacy records from the Facility,[33] and medical records from the Facility.[34] Staff called two witnesses, Melinda Gleason Hester, RN, DNP, an expert in nursing practice who works at the Board as a Lead Practice Consultant,[35] and Christen

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[27] Staff Ex. 9 at 79, 89.

[28] Staff Ex. 9 at 77.

[29] Staff Ex. 9 at 21. No witness explained why there were two different orders for Fentanyl for the same patient.

[30] Staff Exs. 1-10, including Exs. 4a and 5a.

[31] Staff Ex. 1.

[32] Staff Exs. 6 and 7.

[33] Staff Exs. 8.

[34] Staff Ex. 9.

[35] Ms. Hester's resume is at Staff Ex. 10.

Michelle Werley, an investigator with the Board. Ms. Windom was called as a witness by Staff and also testified on her own behalf. Staff did not call anyone from either the Facility or the Agency to testify.

Ms. Windom offered thirteen exhibits, all but two of which were admitted. These exhibits included a copy of the Regulatory Services Annual Report for 2012 – Nursing Facility Actions from the Texas Department of Aging and Disability (DADS) website;[36] the results of a laboratory test drug test on Ms. Windom's hair dated July 10, 2013;[37] 14 certificates of completion and one in-service training for continuing education classes Ms. Windom completed since the incident in question;[38] letters of recommendation;[39] and certificates evidencing her completion of her licensed vocational nurse training with a grade point average of 3.0 or higher and continuing education in IV drug therapy.[40]

2. **Charge I: Administering a medication, Fentanyl, to Patient 536 without a physician's order in violation of Tex. Occ. Code § 301.452(b)(10) and (13); 22 Tex. Admin. Code § 217.11(1)(A) and (B); and 22 Tex. Admin Code § 217.12(1)(A) and (B), (4), and (10)(B).**

a. **Evidence**

Ms. Werley[41] conducted an investigation into the allegations against Ms. Windom.[42] She explained that the Facility's pharmacy records record the time and amount of the withdrawal of medication by a specific nurse for a specific patient. The nurse enters a code which is specific to that nurse, the patient's information, and the amount of medication into an automated cabinet. A

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[36] Respondent Ex. 2.

[37] Respondent Ex. 4.

[38] Respondent Exs. 5 and 13.

[39] Respondent Exs. 7-10,

[40] Respondent Exs. 11-12.

[41] Ms. Werley has a degree in criminal justice. She testified that she is not a nurse and does not have medical expertise. She testified that she did not have knowledge about how nurses chart. Therefore, any opinions regarding the failure of Ms. Windom to follow nursing protocols expressed by Ms. Werley do not carry sufficient weight to prove Staff's allegations and are not included in the summary of evidence.

[42] Ms. Windom was Ms. McFadden at the time of the alleged incidents.

drawer containing the prescribed medication opens and the nurse withdraws the medication. This information is recorded on a computer sheet which is kept by the Facility.

Ms. Werley pointed out that the Facility's pharmacy records indicate that, on September 25, 2011, Ms. Windom withdrew Fentanyl PCA 10 mcg at 9:54 a.m. for Patient 536.[43] However, she noted, the Patient's telephone order records indicate that Fentanyl was discontinued on September 24, 2011, by doctor's order.[44]

The records also contain a MAR for Patient 536 dated "9/25/11 through 9/26/11." The MAR is a listing of all the medications and treatments ordered by the patient's doctor. There are two columns on the MAR, one for the 7:00 a.m. to 7:00 p.m. shift and one for the 7:00 p.m. to 7:00 a.m. shift. The nurse assigned to each shift is required to initial on the MAR when she/he administers the ordered treatment or medication. On the MAR for Patient 536, Ms. Werley pointed out, the order for Fentanyl is crossed through with the notation "Dc'd 9/24/11."[45] Ms. Werley noted that Ms. Windom did not initial on the MAR that she had given the Fentanyl to Patient 536 during her shift.

The medical record also contains Nurses Notes, which are narratives written by hand by the nurses concerning their assessments and treatment of the Patient. In her Nurses Notes for September 25, Ms. Windom indicated that, at 12:00 p.m., Patient 536 reported left flank pain and she gave the Patient Fentanyl by IV. She documented that Patient 536 tolerated the intervention well and that, at 1:00 p.m., the Patient was resting and no distress was noted. She did not document the amount of Fentanyl she gave Patient 536.[46]

In addition to the MAR and the Nurses Notes, Patient 536's medical records contained a seven-page Patient Care/Assessment Flow Sheet, which required the nurse to document various

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[43] Staff Ex. 8 at 4.

[44] Staff Ex. 9 at 80..

[45] Staff Ex. 9 at 85. "Dc'd" is the medical shorthand for "discontinued."

[46] Staff Ex. 9 at 109. The ALJ notes that the Fentanyl was documented as administered approximately two hours after it was withdrawn. Staff asked Ms. Windom why there was a time gap between the withdrawal and the administration and Ms. Windom explained that she had done the documentation later in the day because she was busy taking care of patients. Staff did not allege that the time difference was the basis for any violation.

assessments and treatment given during the shift, including pain levels and interventions given to treat pain. In Patient 536's Care/Assessment Flow Sheet, Ms. Windom also documented that at 12:00 p.m., Patient 536 exhibited aching, throbbing pain at a level of 6 on a scale of 1-10 in the left flank. She documented that she provided "medication" and "repositioning" as interventions in response to the pain. She also noted in that record, at 1:00 p.m., the Patient had responded to the intervention with lessened pain at a level of 3.[47]

Ms. Windom acknowledged during her testimony that she gave Patient 536 Fentanyl on September 25 after it had been discontinued. Her only explanation was that she had not seen the notation on the MAR that it had been discontinued. Ms. Windom suggested that the crossing out of Fentanyl on the MAR might have been done after the fact, because she did not think she would have missed it if it had been there that day. She pointed out that she initialed Patient 536's MAR beside the order for Vancomycin at 9:00 a.m., three lines below the Fentanyl entry, and she doubted she would have missed the notation that the Fentanyl had been discontinued if it was present when she documented the administration of the Vancomycin. In support of her explanation, she pointed to the discontinuation order, which states "Noted" next to a date that looks like "9/29/11," not "9/24/11."[48] She also presented evidence that the Facility had had several citations for pharmacy-related violations in 2011, which may have made them eager to cover up any pharmacy-related mistake they made.[49] She speculated that, based on this evidence, the discontinuation order had been written in the MAR on September 29, 2011, which would have explained her failure to see it during her shift on September 25.

Ms. Windom also pointed out that the only reason for the discontinuation of the Fentanyl on Saturday, September 24, was missing equipment at the Facility, and that the doctor had reinstated the prn (as needed) order for Fentanyl for Patient 536 on Monday, September 26,

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[47] Staff Ex. 9 at 104. The Care/Assessment Flow Sheet contains a chart where "medication" and "repositioning" are listed as two possible interventions for pain and are each assigned a number for the nurse to use to indicate which type of intervention she gave. There is no requirement that the nurse document the type of medication given or the amount on the form.

[48] Staff Ex. 9 at 80.

[49] Respondent Ex. 2.

2011.[50] No other order for pain medication was in effect on September 25, 2011, when she administered it, as the Lortab had also been discontinued on September 24, 2011. Therefore, Ms. Windom argued, there was no risk posed to Patient 536 by her administration of Fentanyl, as the evidence showed that it was an appropriate and effective intervention to address Patient 536's pain.

Ms. Hester testified that, from her review of the records, the Fentanyl appeared to have been discontinued on September 24, 2011. She agreed that it appeared to have been discontinued because of a lack of equipment at the Facility to properly administer the medication rather than because the medication was medically inappropriate.

b. Analysis

Ms. Windom does not dispute that she gave the Fentanyl to Patient 536 after it had been discontinued by doctor's order. Her Nurses Notes support the allegation that she gave the Fentanyl at 12:00 p.m. on September 25, 2011. However, her arguments that the discontinuation order was not noted or written in the MAR until September 29, 2011, rather than September 24, and that the Facility is therefore to blame for her failure to see the discontinuation order, raise an issue regarding her fault in the matter. The notation on the telephone order appears to the ALJ to state "noted 9/29/11." Staff argued it is often difficult to distinguish a handwritten numeral "4" from a "9," and that what appears to be a "9" on the discontinuation order is actually a carelessly written "4." The factors cited by Ms. Windom–that the date noted on the doctor's discontinuation order appears to be September 29, 2011 rather than September 24, 2011, that she would have noticed the discontinuation note on the MAR if it had been written in when she documented the Vancomycin–raise an issue that is sufficient to cast doubt on the reliability of the documentation and whether she was informed that the order was discontinued.

It is Staff's burden to establish by a preponderance of the evidence that the order to discontinue was noted by the nurse on September 24, before Ms. Windom's shift, not after her shift on the 29th. Staff did not present sufficient evidence to support its argument that what appeared to be "9/29" was actually "9/24," to establish the discontinuation notation on the MAR

[50] Staff Ex. 9 at 77.

was written before her shift.[51] Staff also presented no evidence that Ms. Windom had any other means of knowing that the Fentanyl had been discontinued other than the MAR.

Based on this evidence, the ALJ concludes that Staff failed to prove Ms. Windom carelessly failed to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice by administering a medication without a valid doctor's order on one occasion.

3. Charge II: Failing to document the administration of Fentanyl to Patient 536 and Patient 608 on the MAR and/or Nurses Notes in violation of Tex. Occ. Code § 301.452(b)(10) and (13); 22 Tex. Admin. Code § 217.11(1)(A), (B), and (D); and 22 Tex. Admin Code § 217.12(1)(A) and (B), (4), and (10)(B).

a. Evidence

Ms. Hester noted that Fentanyl is an opiate analgesic, a controlled substance, and highly abused. For that reason it is administered through an automated cabinet and requires a nurse to enter a special code, which Ms. Hester compared to a password, that identifies the nurse drawing the medicine. It also identifies the patient receiving the medicine. This is a method of tracking for both billing purposes and for the purpose of controlling highly-abused drugs. Ms. Hester emphasized that it is fundamental to nursing practice to document medications that are administered to a patient because the next nurse will rely on the documentation of what was given to evaluate the patient and how to treat the patient. She stated that a nurse should document in the MAR as well as the Nurses Notes that she administered the medication. Ms. Hester noted that the nurse should state in the Nurses Notes the effectiveness of the medication and any reactions to it. She explained that the risk to the patient that could result from failure to document the administration of the medication is possible overdose. She noted that Fentanyl can suppress respiration if overdosed and thus can result in injury or death.

[51] Ms. Windom also offered evidence that the Facility had been fined repeatedly for pharmacy deficiencies in 2011 as corroboration of her theory that the Facility had deliberately altered the chart to save face. Respondent Ex. 2.

i. Patient 536

The evidence as detailed above shows that on September 25, 2011, Ms. Windom failed to document the administration of Fentanyl to Patient 536 on the MAR. However, as described above, she documented in her Nurses Notes that she administered the Fentanyl by IV to the Patient at approximately 12:00 p.m. She did not, however, note the amount of Fentanyl administered anywhere in the record.[52]

ii. Patient 608

Ms. Werley testified that the pharmacy records document that Ms. Windom "pulled" (withdrew) Fentanyl 50 mcg on September 25 at approximately 9:00 a.m., 1:00 p.m., and 6:00 p.m. for Patient 608. Ms. Werley pointed out that Patient 608's MAR contained two orders for Fentanyl, one for 50 mcg and one for 25 mcg. On Patient 608's MAR, Ms. Windom wrote "9:00 a.m." and her initials beside the order for 25 mcg Fentanyl.[53] There is no notation in the MAR that she gave the remaining 25 mcg of Fentanyl she withdrew at 9:00 a.m. to Patient 608 at any other time during her shift. There is also no notation in the MAR that she gave the Fentanyl she withdrew at 1:00 p.m. or 6:00 p.m. for Patient 608.

Ms. Windom's narrative Nurses Notes indicate that she administered Fentanyl to Patient 608 at 7:30 a.m., that the Patient tolerated it, and that it was effective.[54] There is no indication in the Nurses Notes that she gave the Patient the Fentanyl she withdrew at 1:00 p.m. or 6:00 p.m.

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[52] Ms. Werley also testified that nurse has an obligation to administer medicine with a reasonable period of time after she withdraws the medicine. She noted that the Nurses Notes indicate that Ms. Windom did not administer the Fentanyl until 12:00 p.m., although she withdrew it at 9:54 a.m. However, Ms. Werley did not clearly indicate what in her opinion a reasonable amount of time between the draw and the administration was and whether this was an unreasonable amount of time. Furthermore, Ms. Werley was not shown to be an expert on nursing practices and standards of care. Finally, Staff did not allege that Ms. Windom's failure to administer the medication within a particular time frame was a violation for which the Staff is seeking sanctions.

[53] Staff Ex. 9 at 21.

[54] Staff Ex. 9 at 55. The ALJ notes the inconsistency between when the Fentanyl was drawn (9:00 a.m.) and when it was documented as administered in the MAR (9:00 a.m.) and in the Nurses Notes (7:30 a.m.). Ms. Windom explained that she made the notations in the Nurses Notes later in the day due to the fact that she was busy caring for patients. This discrepancy was not pleaded by Staff as a violation.

In Patient 608's Care/Assessment Flow Sheet, Ms. Windom recorded that, at 8:00 a.m., the Patient complained of pain at a level of 4, and that Ms. Windom treated the Patient with medication for the pain. The Care/Assessment Flow Sheet does not require that the nurse record which medication she administered or how much. Ms. Windom also documented on the Care/Assessment Flow Sheet that the Patient complained of pain at a level of 5 at 1:00 p.m. and that she treated the Patient with medication for the pain at that time, although again not which medication was administered or how much.[55]

Ms. Windom failed to document in the MAR or the Nurses Notes that she administered a third dose of Fentanyl to Patient 608 at or around 6:00 p.m. when she withdrew it.

Ms. Windom agreed that it was her duty to document the administration of the Fentanyl to Patient 608 and that she failed to do so. Ms. Windom's only explanation for not doing so was that Facility staffing was not sufficient, her schedule was so busy that she was not able to document until later in the shift, and she did not remember to document the administration of the medicine to Patient 608. She said that it was her first and only day to work at the Facility. She felt that the Facility was poorly organized, which made it difficult to complete her work timely. She testified that she was not given an adequate orientation to the Facility when she arrived for duty. She had to ask a lot of questions and she said the shift was very busy and seemed understaffed. She stated that she had five patients assigned to her and was unable to take a break and write in the record until the afternoon. She also helped other nurses. In support of her testimony, she offered a letter she had written to the Agency on October 18, 2011, regarding the situation at the Facility.[56]

b. Analysis

Staff alleged that Ms. Windom withdrew Fentanyl 50 mcg at approximately 9:00 a.m., 1:00 p.m. and 6:00 p.m. for Patient 608 but failed to document its administration, except for 25 mcg at 9:00 a.m. Staff's evidence and allegations assume that Ms. Windom administered the

[55] Staff Ex. 9 at 49. The Patient Care/Assessment Flow Sheet requires the nurse to use a number indicating which intervention she used. The Sheet includes a key which assigns a number to "medication" and one to "repositioning." Ms. Windom wrote the numbers for both in the chart for Patient 608.

[56] Staff Ex. 6 at 3-4.

Fentanyl to Patient 608 but did not document it. Staff submitted evidence that the failure to document the administration of the Fentanyl posed a risk to Patient 608 because other health care providers had insufficient information regarding the administration of the medication, which could have affected the treatment provided to Patient 608 and possibly resulted in an overdose of the medication.

In regard to Patient 536, the evidence established that, although Ms. Windom clearly documented the administration of Fentanyl to Patient 536 in the Nurses Notes, she did not "completely and accurately" document the administration of Fentanyl, in that she failed to include the amount she administered. Staff's allegation that she failed to document the administration of the Fentanyl to Patient 536 in the MAR, in addition to the Nurses Notes, was also supported by the evidence.[57] The initialing of the MAR appears to be simply an additional, and duplicative, method of communicating the same information conveyed in the Nurses Notes.

Therefore, the evidence established that, in regard to Patient 608 and Patient 536, Ms. Windom violated the Texas Occupations Code § 301.452(b)(10) and (13) and 22 Texas Administrative Code §§ 217.11(1)(B) and (D) and 217.12(1)(A), (1)(B), and (4).[58]

4. Charge III: Failing to follow the Facility's policy and procedure for wastage of unused portions of the medication in violation of Tex. Occ. Code § 301.452(b)(10) and (13); 22 Tex. Admin. Code § 217.11(1)(A), (B), and (D); and 22 Tex. Admin Code § 217:12(1)(A) and (B), (4), (10)(C), and (11)(B).

a. Evidence

The evidence was undisputed that Ms. Windom withdrew 50 mcg of Fentanyl for Patient 608 at approximately 9:00 a.m. It was also undisputed that Ms. Windom initialed on the MAR for Patient 608 to indicate that she administered 25 mcg of Fentanyl to Patient 608 at approximately 9:00 a.m., but there was no indication in the medical record as to what

[57] 22 Tex. Admin. Code § 217.11(1)(D).

[58] The evidence did not support Staff's allegation that Ms. Windom violated 22 Texas Administrative Code § 217.12(10)(B) *i.e.* that she falsified or made incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances. It was alleged and the evidence established that Ms. Windom failed to document the administration of the drugs, not that she made false, inconsistent, incorrect or unintelligible entries in the record.

Ms. Windom did with the remainder of the Fentanyl. Likewise, the medical record indicates that Ms. Windom withdrew 50 mcg of Fentanyl for Patient 608 at approximately 1:00 p.m. and again at 6:00 p.m. However, there was no indication in the medical record that she administered those two doses of Fentanyl to Patient 608.

Ms. Hester testified that when a nurse does not administer medication after withdrawing it, the nurse must follow proper procedures to "waste" or dispose of the medicine. According to Ms. Hester, the proper method of wasting (disposing of) medication was for two nurses together to "squirt the unused medication into a trash can or sink" and to document the wastage. This provides a way to verify that the medication was not taken by the nurse.

Ms. Werley noted that there was no indication in the Patient 608's medical record that the Fentanyl that Ms. Windom withdrew at 1:00 p.m. and 6:00 p.m. had been administered. She testified that Ms. Windom's failure to document the administration could mean that the medication Ms. Windom withdrew was thrown away, *i.e.* wasted. She also noted that Ms. Windom stated on the Nurses Notes that Patient 608 "denied needs" at 6:30 p.m., which Ms. Werley interpreted to mean that the patient did not need pain medication.[59] Ms. Werley speculated that, if the patient did not need the medication, the Fentanyl that Ms. Windom withdrew at 6:00 p.m. should have been "wasted."

Furthermore, Ms. Werley noted, Ms. Windom initialed on the MAR that she administered 25 mcg of Fentanyl to Patient 608 at 9:00 a.m., but the pharmacy records indicate she withdrew 50 mcg at that time.[60] Ms. Werley testified that, if one assumes from the documentation that Ms. Windom did not administer one-half of the 50 mcg dose withdrawn for Patient 608 at 9:00 a.m., there should have been an indication on the pharmacy computer record that the medication was "wasted." There was no indication on the pharmacy records that Ms. Windom

[59] Staff Ex. 9 at 55.

[60] Patient 608 also had an order for 50 mcg Fentanyl on the MAR; however, Ms. Windom initialed next to the 25 mcg order on the MAR.

had entered the code for wastage or that another nurse's name had been entered as assisting in the wastage.[61]

Ms. Windom admitted that she may have thrown away the remainder (25 mcg) of the medication that she withdrew at approximately 9:00 a.m. She stated that she was not aware of how the system used by the Facility recorded wastage, or whether Fentanyl required a signature of a witness for proper wastage. She said that the medication dispensing system did not have the expected information regarding wastage. She expected that, if another nurse's signature was required for wastage of Fentanyl, it would have a "pop-up," and no pop-up came up. She said that she knew and followed appropriate procedures for wastage during her shift, which included having a second nurse observe the disposal of the medication. She denied Staff's allegation that she failed to properly waste the medication.

Ms. Windom also denied Staff's allegation that she failed to administer the Fentanyl she withdrew at approximately 1:00 p.m. and 6:00 p.m. for Patient 608. She stated that her notation that the Patient "denied needs" at 6:30 p.m. could have meant that she had previously administered the medication and that the Patient was reporting relief. She asserted that it did not mean that she had not administered the medication.

b. Analysis

The evidence established that Ms. Windom administered 25 mcg of the 50 mcg of Fentanyl that she withdrew for Patient 608 at 9:00 a.m., but there is no evidence she administered the other 25 mcg. The evidence also established that Ms. Windom withdrew 50 mcg of Fentanyl at 1:00 p.m. and 6:00 p.m. for Patient 608 and did not document administration or wastage of the medication. Understandably, Ms. Windom was unable to recount precisely what she did on one shift two years ago at a facility where she worked only one time. Without a documentary trail, one can only speculate what occurred. Staff's speculation that Ms. Windom wasted the medication because she did not document administering it is no more supported by the evidence than Ms. Windom's assertion that she either administered the medication or wasted it appropriately.

[61] Staff Ex. 8 at 6.

However, even assuming that Ms. Windom wasted the Fentanyl and did not administer it, the evidence does not support Staff's allegations. Staff's pleadings charge that Ms. Windom "failed to follow *facility* policy and procedure for wastage of the unused portions of the medications."[62] Ms. Hester testified generally about accepted practices, but she did not testify that she had any knowledge of *the Facility's* policies and procedures regarding wastage. Ms. Werley testified generally about systems for dispensing medication and the significance of various notations on the pharmacy records regarding wastage, but did not mention any specific policy or procedure of the Facility. Ms. Werley denied knowledge generally of nursing policies or procedures. No written policies and procedures were admitted, and no one from the Facility testified. No evidence was presented regarding the policies and procedures of the Facility regarding wastage. Therefore, the evidence was insufficient to support Staff's charges as pleaded.

5. Charge IV: Misappropriating Fentanyl belonging to the Facility or the patients or failing to take precautions to prevent such misappropriations, in violation of Tex. Occ. Code § 301.452(b)(10) and 22 Tex. Admin Code § 217:12(1)(B), (6)(G), (8), and (11)(B).

a. Evidence

Ms. Werley testified that once a nurse withdraws a controlled medication, it is her responsibility to either document that it was administered or wasted. If a nurse failed to document either wastage or administration of the medication, Staff assumes that it was misappropriated.[63] Ms. Werley stated that Staff alleged misappropriation because there was no paper trail to prove misappropriation did not occur.

Ms. Hester testified that, because Fentanyl is a type of drug that is often abused in the nursing community, a nurse's failure to properly document its administration and/or wastage raises a suspicion that the nurse is misappropriating the drug.

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[62] Staff Ex. 4a at 8 (Staff's First Amended Notice of Hearing and Formal Charges).

[63] The ALJ notes that this assumption conflicts with Staff's charge 2, that the medication was administered and that Ms. Windom violated nursing standards by not documenting its administration, or charge 3, that Ms. Windom wasted the drugs in violation of the Facility's policy and procedure.

Ms. Windom pointed out that she submitted to a drug test on July 29, 2011, as part of the prescreening process for employment by the Agency, and it was negative.[64] In addition, on advice of her lawyer, she obtained a hair sample drug test on June 10, 2013, and it, too, was negative. Furthermore, she testified that she asked the agency to give her a drug test when it was investigating the incident and they refused. She denied that she was asked to take a drug screen as a result of this incident.

Staff asked Ms. Windom about an undated document titled "Detailed description of incident involving one PCA fentanyl and two fentanyl 50/mcg/mL vials." The document recited that it was created by Aimee Coleman, who "became aware of the issue a few days after [she] took over as the [pharmacist in charge at the Facility] (approximately the week of December 14, 2011)." The document stated,

> Action taken: Nurse in question was an agency nurse. Interim director of nursing notified agency. The agency performed a drug screen, which came back "positive." However, agency was prohibited from releasing information about what came back positive on the drug screen.[65]

Ms. Windom responded that she had no idea why the document stated that she had a positive drug screen. She reiterated she had never taken or been shown the drug screen referenced in the document. Staff did not submit any drug screen taken at the time of the incident.

b. Analysis

Staff argues that its allegation that Ms. Windom misappropriated Fentanyl is supported by the documentation that she withdrew Fentanyl for Patient 608, that Fentanyl generally is known to be highly abused among nurses, and that she failed to document in the record that she administered the Fentanyl to Patient 608 or wasted it. However, the absence of a paper trail in and of itself does not prove misappropriation. Ms. Windom's assertion that she simply failed to document the administration of the medication is an equally plausible deduction to draw from the

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[64] Staff Ex. 6 at 83.

[65] Staff Ex. 7 at 4.

evidence, and one that Staff included in its complaint. The failure to document the administration of the medication, when there was a clear record that it was withdrawn, appears to be just as likely the result of a careless failure to document its administration as the result of misappropriation in the absence of any other evidence to suggest misappropriation.

Furthermore, the ALJ finds that Ms. Windom's testimony denying misappropriation is credible. Staff argued that misappropriation is supported by the fact that there is a high incidence of nurses abusing drugs such as Fentanyl. The evidence that Ms. Windom had a negative drug screen as part of her employment application two months before the incident supported her credibility on this issue. The document in the record suggesting a positive drug test of Ms. Windom at the time of the incident was not credible, as the drug test was never produced and the person writing the statement was not employed at the Facility at the time of the incident, did not testify, and did not state that she had any personal knowledge of any drug test. In fact, the document expressly states that Ms. Coleman did *not* have any personal knowledge of the referenced drug test. Furthermore, Ms. Windom testified that no drug test occurred.

The evidence that Fentanyl is a controlled substance and a highly-abused drug is some evidence that Ms. Windom might have a motive for misappropriating the drug for use by others. However, there was no evidence that Ms. Windom had ever in the past been suspected or accused of misappropriation. A pattern of carelessness regarding the documentation of administration of highly-abused drugs could lend support to Staff's allegation of misappropriation. However, this appeared to be an isolated instance that occurred on one shift. Ms. Windom has been licensed and has practiced as a nurse for five years. There was no evidence presented that she had ever had any disciplinary action brought against her before or since the incident or that any prior allegations of drug misappropriation had been made.

Staff also alleged that Ms. Windom failed to take measures to avoid misappropriation of the Fentanyl but did not submit any evidence regarding what specific measures she failed to take. The evidence established that Ms. Windom used her identification code to withdraw the Fentanyl, which allowed the Facility to track the drug. This is apparently one measure to avoid misappropriation. While she failed to document that she administered some of the medication she withdrew, the evidence did not establish that Ms. Windom actually failed to administer or

dispose of the Fentanyl she withdrew. Obviously, if she administered or disposed of the Fentanyl, those actions would have avoided misappropriation. There was no evidence submitted that the Fentanyl was actually misappropriated. Therefore, the evidence was insufficient to establish that she misappropriated or did not take measures to avoid misappropriation of the Fentanyl.

6. Sanctions

a. Evidence

The evidence supported findings that, on September 25, 2011, Ms. Windom carelessly failed to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice by failing to document the administration of Fentanyl 50 mcg two times and Fentanyl 25 mcg one time to Patient 608, which posed a risk to Patient 608. Furthermore, Ms. Windom failed to record the amount of Fentanyl she administered to Patient 536 one time in the record. Therefore, the evidence established that Ms. Windom violated the Texas Occupations Code § 301.452(b)(10) and (13)[66] and the Texas Administrative Code §§ 217.11(1)(B)[67] and (D)[68] and 217.12(1)(A),[69] (1)(B),[70] and (4).[71]

As to the proper sanction, Ms. Hester testified without explanation that, based on her review of the evidence of the violations and the mitigating and aggravating factors,[72] and

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[66] 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.

[67] Failure to implement measures to promote a safe environment for clients and others.

[68] Failure to accurately 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 response(s); and (vi) contacts with other health care team members concerning significant events regarding client's status.

[69] Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11.

[70] Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings.

[71] Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

[72] Ms. Hester did not go into detail regarding the factors that she considered. She also did not differentiate between the specific violations.

according to the Board's Disciplinary Matrix, both the unprofessional or dishonorable conduct[73] and the failure to conform to the minimum standards of acceptable nursing practice[74] violations were second-tier, level 1 offenses. She recommended a one-year warning, with one year of direct supervision as well as requirements that Ms. Windom be prohibited from consumption of alcohol or other drugs and be required to submit to random drug testing. In addition, she recommended that Ms. Windom take courses in nurse jurisprudence, medication administration, documentation, and critical thinking, and pay a fine of $250.00 for each violation.

Ms. Windom pointed out that she: had been licensed for five years with no other disciplinary issue; had worked only one shift at the Facility and that shift was the only time she had made such errors in documentation; did not deny or try to hide her documentation errors; had made high grades in training for her license; and continued her education and was eager to learn and become a better nurse. Ms. Windom presented letters from two professionals lauding her competency and skills: Lolita Thomas Bruce, PA-C, and Karen Denise Joiner, RN, BSN. Ms. Bruce stated that she had known Ms. Windom for one and one-half years, and she noted that Ms. Windom displayed a "genuine love for her job" and interest in "providing the utmost care and respect" to patients in a long-term care facility that Ms. Bruce found to be rare among care-providers in that setting.[75] She stated that Ms. Windom's skills and experience made her a highly-qualified candidate for entering a registered nurse program. Ms. Joiner stated she has worked with Ms. Windom and stated she is an "excellent nurse" with "great assessment skills."[76]

Ms. Windom also submitted certificates of completion for 14 continuing education courses she has taken in the last two years, since the event at issue in this case, on subjects such as avoiding documentation errors, pain assessment and management, critical thinking, and ethics. She submitted her graduation certificate from Amarillo College's vocational nursing program showing that she graduated in the Fall 2007 with a grade point average of 3.0 or higher[77] and a

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[73] Tex. Occ. Code § 301.452(b)(10).

[74] Tex. Occ. Code § 301.452(b)(13).

[75] Respondent Ex. 8.

[76] Respondent Ex. 9.

[77] Respondent Ex. 12.

certificate showing that she completed a three-day continuing healthcare education course at Amarillo College in "IV Therapy- Theory and Technique" in May 2007.[78]

Ms. Windom also stated that the Facility was very understaffed during the shift she worked there and that she had told the management that it was understaffed. She stated that she no longer did agency nursing after this incident because one could not be sure what kind of facility one would be assigned to. While she admitted her documentation mistakes and agreed that she deserved to be sanctioned for them, she attributed her mistakes in part to her lack of orientation and lack of knowledge regarding the Facility's policies and procedures, but mostly to the understaffing.

b. Analysis

The Board's Disciplinary Matrix establishes recommended sanctions based on whether the conduct meets the criteria of a first, second, or third tier violation. In addition, the Board's rule contains a lengthy list of factors that are to be considered in determining the appropriate sanction level. The Matrix itself lists aggravating and mitigating factors that influence the appropriate sanction level as well.

Ms. Hester stated that she regarded Ms. Windom's violations of Texas Occupations Code § 301.452(b)(10) and (13) as being second tier offenses under the Board's Disciplinary Matrix; however, her testimony was not clear which of Staff's four charges she was referring to. The language establishing the various tiers of offenses is difficult to sort out. The first tier for § 301.452(b)(10) offenses speaks of "isolated" failures. Ms. Windom's failure to document the administration of the medication to Patient 608 occurred three times with one patient, on one day, and during one shift. Her sanctionable conduct appears to meet the common understanding of an "isolated" occurrence, in that it occurred on one day during one shift rather than being an ongoing or repeated occurrence.

Furthermore, to be classified as second tier, an offense must involve a "serious risk" to a patient or repeated acts of "unethical" behavior, neither of which has been established here.

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[78] Respondent Ex. 11.

Ms. Hester stated that failure to document the administration of medication generally could cause other health care providers to have insufficient knowledge of the care provided, and could lead to overdosing the patient. She described Fentanyl as an opiate which if administered in excess, could lead to injury or death. She did not address the risk of overdose specifically in regard to Patient 608 under the specific circumstances in this case. Patient 608 had two doctor's orders for Fentanyl in her chart, which added up to significantly more medication than the amount withdrawn and allegedly administered by Ms. Windom. The pharmacy records reflected her withdrawal of three 50 mcg doses, each four to five hours apart. Both of Patient 608's orders were for Fentanyl every two hours as needed which added up to a potential dosage of 75 mcg every two hours. Ms. Hester did not address the levels of medication needed for an overdose or what circumstances might lead to an overdose in Patient 608's case. The likelihood of overdose seems slight because the amount prescribed was substantially more than the amount Ms. Windom withdrew and allegedly administered.

In regard to Patient 536, Ms. Windom documented the administration of the Fentanyl to Patient 536, but failed to document the amount. While this fails to meet the minimum standard, as in the case of Patient 608, the evidence did not establish the degree of risk involved. The record indicated that she withdrew 50 mcg of the drug for Patient 536, which was less than the amount originally prescribed. The evidence also does not support a finding that Ms. Windom's documentation errors constituted ethical breaches. There was no allegation and no evidence submitted that Ms. Windom's failure to document were deliberate rather than careless. An ethical breach implies intentional conduct, not just an error.

Similarly, there is a lack of clarity as to which tier is appropriate for the Texas Occupations Code § 301.452(b)(13) offense resulting from failure to document the administration of Fentanyl to one patient. The first tier relates to substandard practice with a "low risk" of patient harm, but the second tier seems to encompass both actual harm and any level of risk of harm. It would only make sense to interpret the second tier as addressing offenses with actual harm or some level of risk greater than "low." There was no evidence presented of actual harm. And, as discussed above, the degree of risk of harm to this Patient was not quantified.

The evidence does not establish that Ms. Windom's acts and omissions fit within the language of the second tier for either subsection (10) or (13). Therefore, they must be considered as falling within the first tier.

After the appropriate tier is identified, the Disciplinary Matrix requires an examination of aggravating and mitigating factors in order to determine what sanction level is warranted. Ms. Hester said she considered but did not specifically identify any aggravating or mitigating circumstances. Ms. Windom testified that system dynamics in the practice setting contributed to the problem.[79] Given that this was Ms. Windom's first and only shift at the Facility and her uncontradicted testimony regarding the understaffing and lack of orientation by the Facility, it is likely that the setting contributed to her errors. Furthermore, Ms. Windom has practiced for five years as a licensed vocational nurse and never had a disciplinary action or complaint for similar conduct bought against her.[80] In addition, Ms. Windom presented letters from other professionals lauding her competency and skills, which is some evidence of fitness and competency to practice nursing. She submitted certificates of completion for 14 continuing education courses she has taken since the incident on September 25, 2011, on subjects such as avoiding documentation errors, pain assessment and management, critical thinking, and ethics, which is evidence of her current competency and efforts to correct the conduct leading to the violations.[81] Ms. Windom did not deny or try to hide her violations. She agreed that she made documentation errors and should be sanctioned as a result. There was no actual harm as a result of any of her violations. This evidence of mitigating factors, as well as the isolated nature of the conduct and the lack of significant patient harm or risk of harm, supports sanctions for first tier violations of § 301.452(b)(10) and (13), sanction level I.

Both the remedial education and fine of $250.00 per violation recommended by Ms. Hester are available and warranted by the evidence and the Disciplinary Matrix. However, the practice restrictions and warning are not warranted under the Matrix, nor are the random drug testing and abstinence requirements. Therefore, the ALJ recommends that Ms. Windom be

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[79] 22 Tex. Admin. Code § 213.33(c)(12).

[80] 22 Tex. Admin. Code § 213.33(c)(4), (6), and (7).

[81] 22 Tex. Admin. Code § 213.33(c)(4), (5), (10) and (16).

required to successfully complete remedial education specified by the Board and be required to pay a fine of $250.00.

III. FINDINGS OF FACT

1. Christine Denise Windom has been a vocational nurse (LVN) licensed by the Texas Board of Nursing (Board) since 2008.

2. On August 20, 2013, the Board's staff (Staff) mailed its Notice of Hearing to Ms. Windom.

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 September 10, 2013, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Staff was represented by John F. Legris, Assistant General Counsel. Ms. Windom represented herself. The record closed on the same date.

5. On September 25, 2011, while employed as an agency nurse with AMN Healthcare/Nursefinders, San Diego, California (the Agency), and assigned to the 7:00 a.m. to 7:00 p.m. shift at Plum Creek Specialty Hospital, Amarillo, Texas (the Facility), Ms. Windom administered a medication, Fentanyl, to a patient (Patient 536) without a physician's order.

6. On admission on September 23, 2013, Patient 536 was ordered to be placed on a Patient Controlled Analgesia (PCA) pump for pain, with 10 mcg(micrograms)/ML(milliliter) of Fentanyl by IV, maximum 75 mcg per hour.

7. On September 24, 2011, the order for Fentanyl for Patient 536 was discontinued by written telephone order because the tubing for the PCA pump was unavailable, and an order for Lortab by mouth as needed for pain was substituted. The Lortab order was discontinued that same date by written telephone order because Patient 536 was allergic to it. No other pain medication was ordered.

8. The doctor's telephone order to discontinue Fentanyl was marked as "noted" by a registered nurse on "9/29/11." Ms. Windom documented on Patient 536's MAR three lines below the order for Fentanyl that she administered Vancomycin to Patient 536 at 9:00 a.m.

9. On September 25, 2011, Ms. Windom withdrew 50 mcg of Fentanyl at 9:54 a.m. for Patient 536, which was documented in the pharmacy records.

10. On September 25, 2011, Ms. Windom documented in the Nurses Notes that she administered Fentanyl by IV to Patient 536 at 12:00 p.m., for left flank pain and that, at 1:00 p.m., the Patient was resting and no distress was noted. She did not document the amount of Fentanyl she administered.

11. On September 25, 2011, Ms. Windom noted in the Patient 536's Care/Assessment Flow Sheet that at 12:00 p.m., she gave "medication" and "repositioning" as intervention in response to reported left flank pain at a pain level of 6. She also noted in that record, at 1:00 p.m., the Patient had responded to the intervention with lessened pain.

12. Ms. Windom did not initial in Patient 536's MAR that she administered Fentanyl.

13. The evidence was insufficient to establish that Ms. Windom knew or should have known at the time of her shift that Patient 536's order for Fentanyl had been discontinued on September 24, 2011.

14. Patient 608 had two orders for Fentanyl in her MAR: one for 25 mcg every two hours and one for 50 mcg every two hours.

15. On September 25, 2011, Ms. Windom withdrew Fentanyl 50 mcg for Patient 608 at approximately 9:00 a.m., 1:00 p.m., and 6:00 p.m. These withdrawals were documented in the pharmacy records.

16. Ms. Windom initialed and noted "9:00 a.m." in Patient 608's MAR beside the Patient's prescription for 25 mcg Fentanyl.

17. Ms. Windom failed to note in the MAR or the medical record that she administered the second half (25 mcg) of the 50 mcg dose of Fentanyl she withdrew at 9:00 a.m.

18. Ms. Windom failed to document her administration of Fentanyl 50 mcg to Patient 608 at 1:00 p.m. or 6:00 p.m. in either the Nurses Notes or on the MAR.

19. Ms. Windom documented in the Patient's Care/Assessment Flow Sheet that Patient 608 complained of pain at 1:00 p.m. and that she provided medication at that time, but she did not state which medication or the amount.

20. Fentanyl is an opiate analgesic that is a controlled substance and is highly abused.

21. Ms. Windom's failure to chart her administration of Fentanyl to Patient 608 in the Nurses Notes or the MAR posed a risk to Patient 608 because other health care providers had insufficient information regarding the administration of the medication and the failure to document the administration of the medication could have affected the treatment provided to Patient 608 and possibly resulted in an overdose of the medication.

22. Ms. Windom's failure to document the administration of Fentanyl to Patient 608 and the amount of Fentanyl administered to Patient 536 was careless, rather than deliberate, and therefore not an ethical violation.

23. Ms. Windom's failure to document the administration of Fentanyl to Patient 608 at 1:00 p.m. and 6:00 p.m. exposed Patient 608 to some risk of harm, although the level of risk is unclear, especially because the Patient was prescribed a larger and more frequent dose than that administered by Ms. Windom.

24. No actual harm to Patient 608's or Patient 536's life, health, or safety was shown.

25. System dynamics in the practice setting contributed somewhat to Ms. Windom's failure to document the administration of Fentanyl to Patient 608, in that Ms. Windom had been given inadequate orientation to the Facility and the Facility was understaffed.

26. Ms. Windom's failure to document the administration of medication three times to one patient and the amount of medication administered to another patient on one day during one shift was an isolated violation.

27. Ms. Windom has practiced for five years as a licensed vocational nurse and never had a disciplinary action bought against her other than this one.

28. Other professionals vouched for Ms. Windom's competency and skills in written letters of recommendation. She obtained certificates of completion for 14 continuing education courses she has taken in the last two years on subjects such as avoiding documentation errors, pain assessment and management, critical thinking, and ethics.

29. The evidence was insufficient to establish what the Facility's policies and procedures regarding wastage, or disposal, of unused drugs were and, therefore, was insufficient to prove that Ms. Windom violated those policies.

30. The evidence was insufficient to establish that Ms. Windom misappropriated drugs or failed to take measures to avoid the misappropriation of drugs.

IV. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings 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:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11. 22 Tex. Admin. Code § 217.12(1)(A).

- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings. 22 Tex. Admin. Code § 217.12(1)(B).

- Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established. 22 Tex. Admin. Code § 217.12(4).

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 the requirements to:

- Implement measures to promote a safe environment for clients and others; and

- Accurately and completely report and document:

22 Tex. Admin. Code § 217.11(1)(B) and (D).

8. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.

9. Ms. Windom carelessly failed to perform vocational nursing in conformity with the standards of minimum acceptable level of nursing practice and did not correctly document the administration of medication, thereby failing to promote a safe environment and exposing a patient unnecessarily to the risk of harm to the patient's health.

10. Ms. Windom's conduct is sanctionable. Tex. Occ. Code § 301.452(b)(10) and (13) and 22 Tex. Admin. Code §§ 217.11(1)(B) and (D) and 217.12(1)(A) and (B), (4).

11. If the Board determines that a licensee has committed a sanctionable act, 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 provides guidance in determining the appropriate sanction for a violation. 22 Tex. Admin. Code § 213.33(b).

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

V. RECOMMENDATION

Based on the Findings of Fact and Conclusions of Law, the ALJ recommends that Ms. Windom be required to successfully complete remedial education specified by the Board and be assessed a penalty of $250.00.

SIGNED November 5, 2013.

JOANNE SUMMERHAYS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

SOAH DOCKET NO. **507-13-5432**

IN THE MATTER OF	§	BEFORE THE
PERMANENT CERTIFICATE	§	
NUMBER 214369	§	STATE OFFICE OF
ISSUED TO	§	
CHRISTINE DENISE WINDOM	§	ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

COMES NOW, Staff of the Board of Nursing (hereinafter "Staff" or "Board") and files this, ***Staff's Exceptions to Proposal for Decision*** and would show the Administrative Law Judge as follows:

Staff excepts to Findings of Fact Nos. 8, 13, 29 and 30. Staff specifically excepts to the apparent failure of the Administrative Law Judge (ALJ) to find that Charge I was proven by a preponderance of the evidence.

Finding of Fact No. 5 states essentially that the Respondent, on September 25, 2011, "administered a medication, Fentanyl, to a patient (Patient 536) without a physician's order." This Finding of Fact alone substantiates Charge I. This finding must have been based upon the Respondent's own admission during her testimony that she gave Patient 536 Fentanyl on September 25 after it had been discontinued (See PFD page 11, para. 2). In her analysis set forth on page 12, the Administrative Law Judge (ALJ) notes that "Ms. Windom does not dispute that she gave the Fentanyl to Patient 536 after it had been discontinued by doctor's order". Any explanation by Respondent as to why this occurred or how it occurred does not negate the violation which occurred. Respondent's explanations provide potentially some mitigation which should be considered solely for purposes of sanctions.

I. Finding of Fact No. 8

In this regard, Finding of Fact No. 8 conflicts with Finding of Fact No. 5. If, in fact, the physician's order had been discontinued on September 29, 2011, instead of September 24, 2011, then there would be no violation as alleged in Charge I. Staff argued at the hearing, however, that the order was discontinued on September 24, 2011. This is the only interpretation of the entry found in the Staff's Exhibit No. 9 at page 85, which makes sense considering the other evidence in the record. As the ALJ rightly pointed out, the Respondent "... speculated that,... the discontinuation order had been written in the MAR on September 29, 2011..." (PFD at page 11). Finding of Fact No.8, therefore, is based upon Respondent's ***speculation,*** and Staff would except to this Finding. The date should be listed in the Finding as September 24, 2011.

II. Finding of Fact No. 13

With regard to Finding of Fact No. 13, it is obviously incorrect. Ms. Windom admitted to the essential elements of Charge I in her testimony. It is no excuse for Respondent to state that she had not seen the notation on the MAR. It was her duty to review those entries and insure that she was administering medications properly. Staff would point out that the Respondent offered alternative self-serving explanations as to how this could have occurred. The ALJ incorrectly chose to believe one of these explanations. In any event, the explanations do not defeat Charge I; they should be considered only as mitigation on the issue of sanctions. Finding of Fact No. 13 should be deleted.

III. Finding of Fact No. 29

With regard to Charge III, concerning the wastage issue, Staff excepts to Finding of Fact No. 29; it should be deleted. The essence of good nursing practice is, as testified to by both Ms. Werley

and Dr. Hester, that after withdrawing medication for a patient, the nurse must either administer the medication or properly waste it. The ALJ states on pages 16 and 17 of the PFD that "the evidence was undisputed that Ms. Windom withdrew 50 mcg. of the Fentanyl for Patient 608 at approximately 9:00 AM. It was also undisputed that Ms. Windom initialed on the MAR for Patient 608 to indicate that she administered 25 mcg. of Fentanyl to Patient 608 at approximately 9:00 AM, but there was no indication in the medical record as to what Ms. Windom did with the remainder of the Fentanyl," (PFD at pp 16, 17). Ms. Windom herself admitted that she may have thrown away the remainder (25 mcg) of the medication. (PFD p. 18). Thus Ms. Windom failed to properly waste the remaining 25 mcg. of this medication.

There were no indications in either the MAR, the pharmacy records, Staff's Exhibit No. 8, or elsewhere in the medical record that the medication withdrawals for Patient 608 at 1:00 PM and 6:00 PM were administered or wasted. The absence of entries as to wastage may be relied upon to show that a nurse failed to properly waste. Thus, Staff would argue that Charge III has been proven by a preponderance of the evidence.

IV. Finding of Fact No. 30

Staff excepts also to Finding of Fact No. 30. Staff argues that Ms. Windom misappropriated any medications not shown to have been properly administered or wasted.

V. Conclusion

Staff excepts to the Administrative Law Judge's sanction recommendation. If Charges I, II, III, and IV are proven by a preponderance of the evidence, as here argued, then an appropriate sanction would be the one identified and testified to by Dr. Hester during the hearing. The ALJ should amend her Proposal for Decision accordingly.

III. Prayer

WHEREFORE PREMISES CONSIDERED, Staff prays the Administrative Law Judge make the foregoing requested modifications to the Proposal For Decision.

Respectfully submitted,

TEXAS BOARD OF NURSING

John F. Legris, Assistant General Counsel
State Bar No. 00785533
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
Ph: (512) 305-6823; Fax: (512) 305-8101

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing ***Staff's Exceptions to Proposal for Decision*** was sent by Certified Mail, Address Service Requested, No. 91 7199 9991 7031 6341 4096, this, the 22nd day of November, 2013, to: Christine Denise Windom, 5704 Vista Park Lane, Sachse, TX 75048.

John F. Legris, Assistant General Counsel

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

December 12, 2013

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

VIA FACSIMILE NO. (512) 305-8101

RE: Docket No. 507-13-5432; Texas Board of Nursing v. Christine Denise Windom

Dear Ms. Thomas:

I have reviewed Staff's Exceptions filed November 20, 2013, to the Proposal for Decision (PFD) issued in the above-referenced case on November 5, 2013. Respondent did not file a reply or exceptions. For the reasons expressed in the PFD, my recommendation remains unchanged.

Staff excepts to the following findings of fact:

8. **The doctor's telephone order to discontinue Fentanyl was marked as "noted" by a registered nurse on "9/29/11." Ms. Windom documented on Patient 536's MAR three lines below the order for Fentanyl that she administered Vancomycin to Patient 536 at 9:00 a.m.**

9. **The evidence was insufficient to establish that Ms. Windom knew or should have known at the time of her shift that Patient 536's order for Fentanyl had been discontinued on September 24, 2011.**

Staff excepts to these findings on the basis that they are inconsistent with Finding of Fact 5:

5. **On September 25, 2011, while employed as an agency nurse with AMN Healthcare/Nursefinders, San Diego, California (the Agency), and assigned to the 7:00 a.m. to 7:00 p.m. shift at Plum Creek Specialty Hospital, Amarillo, Texas (the Facility), Ms. Windom administered a medication, Fentanyl, to a patient (Patient 536) without a physician's order.**

As explained in the PFD, the doctor's order to discontinue Fentanyl was given by telephone on September 24, 2011. Staff relied entirely on the notation in the MAR and the written telephone order to prove carelessness on the part of Ms. Windom. However, the evidence did not establish that the registered nurse marked the order as "noted" and made the entry on the MAR on that date. There was evidence presented that indicated the note discontinuing the order was noted on the MAR on September 29, 2011—four days after Ms. Windom's shift on September 25, 2011. No evidence was presented by Staff to counter this evidence. Staff had the burden of proof by a preponderance of the evidence. Therefore, the evidence was insufficient to prove that Ms. Windom was careless in that, although Ms. Windom gave the medication in error, the evidence did not prove that she knew or should have known that she was making an error. The evidence did not support Staff's allegation that action taken by Ms. Windom violated the statues or Board rules because the legal authorities cited required a finding of carelessness or repetitive conduct, neither of which were supported by the evidence.

Staff also appears to contend that the factual finding of lack of carelessness is irrelevant to a finding of a violation of statutes or Board rules. Contrary to Staff's contention, the Board rules define the statutorily prohibited "unprofessional conduct" as:

- *Carelessly* failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11. 22 Tex. Admin. Code § 217.12(1)(A).
- *Carelessly* or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings. 22 Tex. Admin. Code § 217.12(1)(B).

I recommend adding the words "on September 25, 2011" to Finding of Fact 8 to clarify that the date Ms. Windom gave the medication was before the date "noted" on the telephone order and stated as discontinued on the MAR.

Staff also excepted to Finding of Fact 28:

28. The evidence was insufficient to establish what the Facility's policies and procedures regarding wastage, or disposal, of unused drugs were and, therefore, was insufficient to prove that Ms. Windom violated those policies.

Staff's argument ignores the express language of the Board rule regarding wastage, and Staff's allegations. Staff's pleadings charge that Ms. Windom "failed to follow *facility* policy and procedure for wastage of the unused portions of the medications."[1] Ms. Hester testified generally about accepted practices, but she did not testify that she had any knowledge of *the Facility's* policies and procedures regarding wastage. Ms. Werley testified generally about systems for dispensing medication and the significance of various notations on the pharmacy records regarding wastage, but did not mention any specific policy or procedure of the Facility.

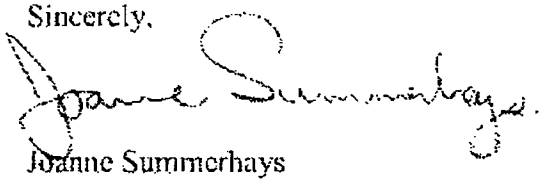
[1] Staff Ex. 4a at 8 (Staff's First Amended Notice of Hearing and Formal Charges)

Ms. Werley denied knowledge generally of nursing policies or procedures. No written policies and procedures were admitted, and no one from the Facility testified. No evidence was presented regarding the policies and procedures of the Facility regarding wastage. Therefore, the evidence was insufficient to support Staff's charges as pleaded.

Staff also excepted to Finding of Fact 30, but made no argument, cited no rule or law, and pointed to no evidence to support its exception.

For the reasons expressed above and in the PFD, my recommendation remains unchanged.

Sincerely,



Joanne Summerhays
Administrative Law Judge

JS/mle

xc: John F. Legris, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA FACSIMILE NO. (512) 305-8101**
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA FACSIMILE NO. (512) 305-8101**
Christine D. Windom, LVN, 5704 Vista Park Lane, Sachse, TX 75048 – **VIA REGULAR MAIL**