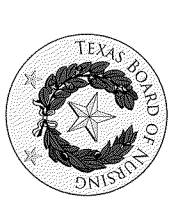

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

DOCKET NUMBER 507-13-5618

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 616887	§	**OF**
ISSUED TO	§	
SANDRA C. LARA	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: SANDRA C. LARA
C/O MARC C. MEYER, ATTORNEY
33300 EGYPT LANE, STE B-200
MAGNOLIA, TX 77354

KERRIE JO QUALTROUGH
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 16-17, 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 recommendation that the Board adopt the PFD regarding the registered nursing license of Sandra C. Lara with changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

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

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

Modification

The Board has authority to review and modify a PFD in accordance with the Government Code §2001.058(e). Specifically, §2001.058(e)(1) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ or vacate or modify an order issued by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions.

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 a Probated Suspension[2]. The Board further finds that probationary conditions should be imposed as part of the Probated Suspension, for a two year period[3].

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 3 through 13 and 15 through 17 and Conclusions of Law Numbers 4 through 10, raises concerns about the Respondent's ability to practice nursing safely. First, the Respondent's conduct posed a serious risk of harm to vulnerable patients[4]. Although it did not occur in this case, there could have been severe consequences from the Respondent's failure to document[5]. The Respondent's conduct evidences carelessness and inattention to detail. The Respondent should have been keenly aware of the importance of accurately and completely documenting the administration of controlled substances, given the Respondent's prior chemical dependency and disciplinary history with the Board[6]. Further, the Board remains cognizant that it must consider taking a more severe disciplinary action if an individual has been previously disciplined by the Board or is being disciplined for multiple violations of the Nursing Practice Act (Occupations Code Chapter 301) than would be taken if the individual had not been previously disciplined or is being disciplined for a single violation[7]. The Respondent committed several violations of the Nursing Practice Act

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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 collectively warrants a second tier, sanction level II sanction. See pages 15-16 of the PFD.

[3] See 22 Tex. Admin. Code §213.33(e)(6), which states that "[T]he Board may determine that the order of suspension be enforced and active for a specified period and/or probated with reasonable probationary stipulations as a condition for lifting or staying the order of suspension." Reasonable probationary stipulations may include practice for a specified period of not less than two years under the direction of a registered nurse or vocational nurse designated by the Board.

[4] See adopted Findings of Fact Numbers 3-13 and Conclusions of Law Numbers 8 and 10; and pages 15-16 of the PFD.

[5] See page 15 of the PFD.

[6] See adopted Findings of Fact Numbers 15-17 and pages 15-16 of the PFD.

[7] Occupations Code §301.4531 and 22 Tex. Admin. Code §213.33(b).

and Board rules and was issued Agreed Orders in 1999, 2001, and 2002[8].

The Board also recognizes that the Respondent presented mitigating evidence during the hearing. Systems issues at the facility may have contributed to the Respondent's violations[9]. Further, the Respondent successfully completed five years of negative drug screening and submitted a drug screen in 2012 that was negative[10].

The Board has reviewed the aggravating and mitigating factors in this case. At the outset, the Board generally agrees with the ALJ that the appropriate sanction in this matter is a Probated Suspension. However, the ALJ did not recommend any probationary conditions, nor did she recommend a time period for the Order. 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), the Board finds that probationary conditions are warranted, for a two year monitoring period.

The Board finds that remedial education courses and a fine of $750 should be imposed against the Respondent's license[11]. Based on the seriousness of the Respondent's conduct, the potential for patient harm, and the lack of deterrent effect of the Board's prior Orders, the Board finds that employer notifications, supervised practice, and quarterly employer reports are warranted for the two year monitoring period. These stipulations will enable the Board to remain informed about the Respondent's practice while under the terms of this Order and ensure that the Respondent's practice is being supervised in accordance with the terms of this Order. The Board also finds that the Respondent should be restricted from practicing in certain independent, autonomous, or unsupervised settings. These restrictions are necessary to ensure that the appropriate type of supervision is provided for the Respondent. Supervision that would be required under this Order is not typically provided for in autonomous settings, such as home health settings. Further, these restrictions are necessary to ensure a consistency in the Respondent's supervision so that patterns of practice may be effectively monitored and, if problematic, identified quickly. It is difficult to consistently observe a nurse's practice if the nurse works for several different employers or works for an agency, which may place the nurse at different facilities on a short term basis. Further, these conditions are authorized under 22 Tex. Admin. Code §213.33(e)(6) and are consistent with Board precedent and prior administrative decisions involving similar violations.

IT IS THEREFORE ORDERED, that Registered Nurse License Number 616887, previously issued to SANDRA C. LARA, to practice nursing in Texas is/are hereby SUSPENDED for a period of two (2) years with the suspension STAYED and Respondent is hereby placed on PROBATION for two (2) years with the following terms of probation:

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[8] See adopted Findings of Fact Numbers 15-17.

[9] See adopted Finding of Fact Number 14 and page 16 of the PFD.

[10] See adopted Findings of Fact Numbers 18-19.

[11] See 22 Tex. Admin. Code §213.33(f) and §213.32(6). Section 213.32(6) permits issuance of a fine in conjunction with other sanctions authorized by Board rules. Respondent's conduct resulted in multiple violations of Board rules. These violations support imposition of a $250 fine for the first occurrence and an additional $500 for a second violation.

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, the 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.

(1) 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.

(2) 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/compliance.

(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/compliance.

(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/compliance.

(5) RESPONDENT SHALL pay a monetary fine in the amount of seven hundred fifty dollars ($750). RESPONDENT SHALL pay this 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, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING PROBATION CONDITIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions 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 probation conditions on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

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

(8) For the first year of employment as a Nurse under this Order,

RESPONDENT SHALL be directly 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. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the probation period, 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.

(10) 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 two (2) years of employment as a nurse.

IT IS FURTHER ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IT IS FURTHER 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 16th day of April, 2014.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-13-5618 (January 31, 2014).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

January 31, 2014

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: SOAH Docket No. 507-13-5618; *In the Matter of Sandra C. Lara, Permanent Certificate No. 616887*

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,

Kerrie Jo Qualtrough
Administrative Law Judge

KJQ/vg
Enclosures
XC: John F. Legris, Assistant General Counsel, 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(s); Certified Evidentiary Record) – **VIA INTERAGENCY**
Marc C. Meyer, RN, JD, Law Office of Marc Meyers, PLLC, 33300 Egypt Lane, Ste. B-200, Magnolia, TX 77354-2739 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-13-5618

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
SANDRA C. LARA, PERMANENT CERTIFICATE NO. 616887, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

In four separate formal charges, the Staff of the Texas Board of Nursing (Board) seeks to take disciplinary action against the permanent certificate of Sandra C. Lara (Respondent) for numerous violations involving the withdrawal of two controlled substances, Morphine and Hydromorphone. After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds that Respondent committed one of the four charges and recommends that the Board suspend Respondent's license and probate that suspension.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Matters concerning notice and jurisdiction were undisputed. Therefore, those matters are set out in the findings of fact and conclusions of law without further discussion here.

ALJ Kerrie Jo Qualtrough convened the hearing on the merits on December 10, 2013, at the State Office of Administrative Hearings in Austin, Texas. Assistant General Counsel John F. Legris represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on December 10, 2013.

II. APPLICABLE LAW

Chapter 301 of the Texas Occupations Code and the Board's rules govern the practice of nursing in Texas. Under chapter 301, a person is subject to disciplinary action for unprofessional

or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public.[1] Under the Board's rules, "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;[2]
- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[3]
- Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established;[4]
- Falsification of or making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances;[5]
- 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 incidents;[6]
- 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;[7]
- Misappropriating, in connection with the practice of nursing, anything of value or benefit, including real or personal of the client, employer, or any other person or entity, or failing to take precautions to prevent such misappropriation;[8] and
- Diversion or attempts to divert drugs or controlled substances.[9]

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[1] Tex. Occ. Code § 301.452(b)(10).

[2] 22 Tex. Admin. Code § 217.12(1)(A).

[3] 22 Tex. Admin. Code § 217.12(1)(B).

[4] 22 Tex. Admin. Code § 217.12(4).

[5] 22 Tex. Admin. Code § 217.12(10)(B).

[6] 22 Tex. Admin. Code § 217.12(10)(C).

[7] 22 Tex. Admin. Code § 217.12(11)(B).

[8] 22 Tex. Admin. Code § 217.12(6)(G).

[9] 22 Tex. Admin Code § 217.12(8).

In addition, a nurse is also subject to disciplinary actions 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 a risk of harm.[10] 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;[11]
- Implement measures to promote a safe environment for clients and others;[12] 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 responses; and
  (vi) contacts with other health care team members concerning significant events regarding client's status.[13]

III. DISCUSSION

Respondent has been practicing nursing for approximately 10 years, but was first licensed to practice in Texas on June 13, 1995.[14] From December 2011 through January 2012, the time period relevant to this hearing, Respondent was employed by Memorial Hermann Northwest Hospital (Hermann Northwest) in Houston, Texas.

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[10] Tex. Occ. Code § 301.452(b)(13).

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

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

[13] 22 Tex. Admin. Code § 217.11(1)(D).

[14] Staff Ex. 14 at 1.

A. Charge I

1. Staff's Allegation and Evidence

Staff alleged in its Formal Charges that on or about January 26, 2012, at 1939 hours, Respondent withdrew Hydromorphone from the medication dispensing unit for Patient No. 027503 without a valid physician's order.[15] Staff contends that the patient was discharged and off the unit at 1811 hours. Therefore, Respondent's conduct "was likely to deceive the hospital pharmacy and place them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act)."[16] Staff asserts that this conduct violated the nursing practice standards in 22 Texas Administrative Code § 217.11(1)(A) and (1)(B) and constituted unprofessional conduct under 22 Texas Administrative Code § 217.12(1)(A), (1)(B), and (10).

Staff witness, Kristen Worley, is a supervising investigator with the Board. She testified that the patient's records show that on December 26, 2012, at 1811 hours, the patient was discharged and "off unit."[17] However, the pharmacy records show that, at 1939 hours, after the patient was discharged, Respondent pulled Hydromorphone for this patient from the dispensing system.[18] In addition, there is no entry in the Medication Administration Record (MAR)[19] or in the Nurses' Notes[20] corresponding with this pharmacy pull. However, Ms. Worley conceded that she could not tell from the records when the patient physically left the hospital.

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[15] Staff Ex. 4 at 5.

[16] Staff Ex. 4 at 5.

[17] Staff Ex. 10 at 188.

[18] Staff Ex. 9 at 2.

[19] Staff Ex. 10 at 188.

[20] Staff Ex. 10 at 188.

2. Respondent's Evidence

Respondent testified that she had previously cared for this patient,[21] who was suffering from metastatic cancer and was being transferred to hospice care. When Respondent withdrew the Hydromorphone, the patient was on an ambulance gurney, awaiting transport, and was "screaming" in pain. Respondent explained that due to the conflicting duties of other nurses, the patient was not attended by a nurse. In an attempt to help the patient, Respondent went to the Pyxis medication dispensing unit, obtained the Hydromorphone, and administered it to the patient. According to Respondent, Pyxis would not allow a nurse to withdraw a medication from the system unless there was a physician's order prescribing that medication.[22] Respondent testified that "time went on" and, when she went to document that she had administered the medication, she was unable to access the patient's records in the system, presumably because of the discharge. She stated that the ambulance personnel were aware that she had given the medication to the patient. However, Respondent stated that she did not take further steps to document the administration of the Hydromorphone once the system denied her access to the patient's records.

Respondent pointed out that even though the patient was discharged at 1811 hours, the patient was still treated by other hospital staff after the discharge. The patient's records indicate that at 1830 hours, a nurse took the patient's vital signs and documented them in the record.[23] Therefore, the patient's records indicate that the patient was still physically in the hospital, even though the records note that the patient was discharged.

3. ALJ's Analysis

In Charge I, Staff alleged that Respondent violated various rules because she "withdrew Hydromorphone from the Medication Dispensing System . . . at 1939, without a valid

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[21] *See also* Staff Ex. 5b.

[22] Staff Ex. 5b at 1.

[23] Staff Ex. 10 at 189.

physician's order. In fact, the patient was discharged and off the unit at 1811."[24] However, the preponderance of the evidence does not support Staff's allegation. Although the records indicate that the patient was technically discharged at 1811 hours on January 26, 2012,[25] the records also show that the patient was still physically present in the hospital after the discharge because the patient's vital signs were taken and recorded at 1830 hours. Furthermore, the Pyxis dispensing machine would not have dispensed the Hydromorphone to Respondent in the absence of a physician's order for this patient.[26] Staff witness, Melinda Hester, Doctor of Nursing Practice and the Board's lead practice consultant, testified that although a physician's order is not in the evidentiary record, it is a reasonable assumption that this patient had a physician's order for Hydromorphone. Also, Dr. Hester testified that it takes time to transport a patient to a long-term, acute-care facility,[27] and nurses cannot ignore a patient if she is still in the unit. In the ALJ's opinion, Respondent testified credibly about this patient and the administration of Hydromorphone. Therefore, the ALJ finds that Respondent acted appropriately in administering the controlled substance to this patient pursuant to a physician's order while the patient was at Hermann Northwest. Accordingly, the ALJ concludes that Staff failed to meet its burden to prove that Respondent withdrew the medication without a valid physician's order after the patient had been discharged.

B. Charge II, III, and IV

1. Staff's Allegation and Evidence

Staff made three separate charges based on the same evidentiary record. As set out in the table below, Staff's evidence shows that in December 2011 and January 2012, Respondent withdrew Morphine five times for three separate patients and withdrew Hydromorphone one time for the patient discussed in Charge I, but failed to document what happened to the medications:

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[24] Staff Ex. 4 at 1.

[25] Staff Ex. 10 at 188.

[26] Staff Ex. 5b at 1.

[27] The ALJ assumes that hospice care takes place in a long-term acute-care facility.

Patient	Date and Time	Medication	MAR	Nurses' Notes	Waste
601349[28]	12/21/11 at 0255 hrs	Morphine	None	None	None
567501[29]	12/26/11 at 0348 hrs	Morphine	None	None	None
327506[30]	01/07/12 at 2142 hrs	Morphine	None	None	None
327506[31]	01/08/12 at 0455 hrs	Morphine	None	None	None
327506[32]	01/08/12 at 2136 hrs	Morphine	None	None	None
027503[33]	01/26/12 at 1939 hrs	Hydromorphone	None	None	None

Ms. Worley reviewed the patient records for the four patients and documented the absence of entries showing what was done with the two controlled substances, Morphine and Hydromorphone. According to Ms. Worley, Respondent did not document in the MAR or in the Nurses' Notes that she administered the medications to the patients. Nor did she document in the pharmacy records that she wasted the medication. Based on this evidence, Staff alleged that Respondent committed the following violations:

Charge II: Respondent failed to completely and accurately document the administration of the medication in the patients' MARs and Nurses' Notes, and Respondent's conduct violated 22 Texas Administrative Code § 217.11(1)(A), (1)(B), and (1)(D) and constituted unprofessional conduct under section 217.12(1)(A), (1)(B), (4), and (10)(B).

Charge III: Respondent failed to follow the hospital's policy and procedures for wastage of the unused medication, and Respondent's conduct violated 22 Texas Administrative Code § 217.11(1)(A), (1)(B), and (1)(D) and constituted unprofessional conduct under section 217.12(1)(A), (1)(B), (4), (10)(C), and (11)(B).

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[28] Staff Ex. 9 at 6; Staff Ex. 12 at 82-83, 164.

[29] Staff Ex. 9 at 4; Staff Ex. 11 at 27, 97-99.

[30] Staff Ex. 9 at 5; Staff Ex. 13 at 251, 481-84.

[31] Staff Ex. 9 at 5; Staff Ex. 13 at 251, 509.

[32] Staff Ex. 9 at 5; Staff Ex. 13 at 251, 692.

[33] Staff Ex. 9 at 2, Staff Ex. 10 at 44, 188.

Charge IV: Respondent misappropriated or failed to take precautions to prevent such misappropriation of the Morphine and Hydromorphone in violation of 22 Texas Administrative Code § 217.12(1)(B), (6)(G), (8), and (11)(B).

According to Dr. Hester, a nurse has a duty to document in both the MAR and in the Nurses' Notes if she administered medication to a patient. If a nurse wastes the medication, the wastage must be witnessed and documented in the pharmacy record. Dr. Hester further testified that it is not acceptable for a nurse to pull a medication for a colleague, and this can only be done in an emergency and must be properly documented.[34] Dr. Hester opined that Respondent violated the Nursing Practices Act and the Board's rules.

Staff also points out that Respondent has prior board orders for the same types of violations. On July 22, 1999, the Board issued an agreed order finding that, in May of 1999, Respondent failed to document on 10 occasions the administration of Demerol and Morphine, that she withdrew Demerol for one patient without a valid physician order, and that she withdrew Morphine but did not document wastage.[35] As a sanction, the Board imposed a Reprimand with Stipulations.

On August 1, 2001, the Board again issued an order finding that Respondent withdrew Demerol without a physician's order, that she failed to document administering and wasting Demerol and Morphine, and that she misappropriated Demerol.[36] The 2001 Board order also contained a finding of fact that Respondent engaged in the intemperate use of Demerol.[37] Pursuant to the 2001 Board order, Respondent voluntarily surrendered her license to practice nursing.[38]

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[34] Staff did not plead in its Formal Charges that pulling a medication for a colleague is a violation of the Board's rules.

[35] Staff Ex. 14 at 2, 3.

[36] Staff Ex. 15 at 2, 3.

[37] Staff Ex. 15 at 3.

[38] Staff Ex. 15 at 4.

On October 24, 2002, the Board reinstated Respondent's license, and established Petitioner's date of sobriety as May 1, 2001.[39] The Board required Respondent to complete the Texas Peer Assistance Program for Nurses (TPAPN) and, after successful completion, submit to periodic drug screens during the 2-year stipulation period.[40] Respondent was also required to attend weekly substance-abuse support groups, in addition to other stipulations on her practice.[41] Staff characterized this Board order as a "fairly arduous" and "unusual" order, and Respondent successfully fulfilled the provisions of the 2002 reinstatement order in March 2007. According to Dr. Hester, although Respondent satisfied the requirements in the 2002 Board order, she may now be relapsing, as evidenced by the current violations which are similar to the violations in the prior Board orders.

2. Respondent's Evidence

Respondent testified that, other than the patient in Charge I, she does not recall the individual patients or the drug pulls that are the subject of Charges II, III, and IV.[42] According to Respondent, her employer terminated her employment regarding the administration of the Hydromorphone to the patient under Charge 1, and she was not questioned regarding the other drug pulls. Therefore, she does not recall the specific circumstances of each drug pull.

Respondent further testified that the ICU was very chaotic, and she sometimes worked as a charge nurse, helping out physicians and other nurses. Therefore, she may have pulled medications that were administered by the nurses who were responsible for the patients' care.[43] As an example of this, Respondent referred to Patient No. 327506. According to Respondent, the evidence shows that on three occasions, Respondent pulled medication pursuant to a

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[39] Staff Ex. 16 at 3.

[40] Staff Ex. 16 at 6, 7-8

[41] Staff Ex. 16 at 7-8.

[42] *See also* Staff Ex. 5b at 2 (In her response to Staff's Formal Charges, Respondent stated, "It has been over 14 months since I was notified of not documenting these 5 narcotics and I honestly can't remember these patients by their medical record numbers and probably at this point even if I had their name[s].").

[43] For example, the records for Patient No. 601349 show that Respondent pulled the medication at 0255 hours and another nurse administered the medication at 0511 hours.

physician's order, but Respondent's name does not show up in the patient's records at any time during the shifts in question.[44] Respondent asserts that this may indicate that she was helping out other nurses and not responsible for the care of the respective patients during those shifts and times when the pharmacy records indicate she pulled the medications.[45] She further stated that around that time, Hermann Northwest had installed a new system, which only added to the chaos in a very busy ICU. The new system required the scanning of bracelets to enter information into the system, and sometimes that scan would not work. If that occurred, then a nurse would have to manually enter the information into the system. Respondent stated that she may have forgotten to document.[46]

Respondent also attempted to address the wastage allegations listed in Staff's Charge III. Respondent stated that "I did not need a witness for the Morphine, the order was for 4 mg I.V. . . . and I only medicated [patient] with 2 mg. – Morphine come in 2 mg. vial – I gave the lower dose and it did not require a witness."[47] Therefore, Respondent appears to argue that if Staff's allegations are true, they do not demonstrate that she wasted the medication.

Regarding her prior Board orders, Respondent stated that following surgery on her neck 12 years ago, she became addicted to Norco,[48] but she had not been addicted to Morphine. She agreed to surrender her nursing license because of her chemical dependency, but she has been clean and sober for 12 years.[49] Also, Respondent points out that as a result of the Hydromorphone drug pull for Patient No. 027503, she consented to her employer's request for a drug screen, and the results of that screen were negative.[50] She further testified that she did not

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[44] Staff Ex. 13 at 470-515, 674-723.

[45] There are no entries in this patient's records that indicate a nurse administered morphine at dates and times corresponding to Respondent's drug pulls. Staff Ex. 13 at 251, 481-84.

[46] Staff Ex. 5b at 2.

[47] Staff Ex. 5 at 2-3. Respondent testified that when she submitted her written statements found in Staff Exs. 5 and 5b, she was only responding to the assertions in the Formal Charges and did not have the patients' records to review.

[48] Resp. Ex. D at 1.

[49] Staff Ex. 5 at 4.

[50] Staff Ex. 7.

divert the controlled substances for her own use and did not take the medications from the premises of Hermann Northwest.

3. ALJ's Analysis

Regarding Charge II, the ALJ concludes that Staff met its burden to prove that Respondent violated 22 Texas Administrative Code § 217.11(1)(A) and (1)(D). The evidence indicates that Respondent pulled the listed medications for those patients, but there is no record of what she did with the medications. Therefore, the patients' records are not accurate or complete, as required by section 217.11(1)(D), and Respondent failed to conform to the Board's rules, as required by section 217.11(1)(A).

However, the ALJ concludes that Staff did not prove the other violations alleged in Charge II. Other than speculation that she might have assisted other nurses as a charge nurse or that she may forgotten to document, there is no evidence regarding Respondent's conduct with regards to the Morphine.[51] Also, Respondent's prior Board orders are not sufficient to support a finding that Respondent's conduct in this case, whatever that might be, rises to the level to support the other violations alleged by Staff. Without evidence of Respondent's actual conduct in this case regarding the other alleged violations in Charge II, the ALJ cannot find that Respondent failed to implement measures to promote a safe environment for her patients, carelessly or repeatedly failed to perform nursing in conformity with the minimum standards or generally accepted nursing standards, carelessly or repetitively endangered a patient's health, or falsified or made incorrect, inconsistent, or unintelligible entries in a record regarding controlled substances. Therefore, the ALJ concludes that Staff did not meet its burden to prove that Respondent violated 22 Texas Administrative Code § 217.11(1)(B) or § 217.12(1)(A), (1)(B), (4), or (10)(B).

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[51] As stated previously in this proposal for decision, the ALJ finds that Respondent withdrew and administered the Hydromorphone appropriately. Charge II addresses Respondent's failure to document that she administered the Hydromorphone to the patient.

Regarding Charge III, the ALJ finds that Staff did not meet its burden to prove that Respondent "withdrew Morphine and Hydromorphone from the medication dispensing system for patients, but failed to follow the facility's policy and procedures for wastage of any the unused portions of the medications . . . ."[52] There is no evidence in the record that Respondent actually wasted the medication, and there is no evidence of Hermann Northwest's policies or procedures regarding wastage. Therefore, Staff did not meet its burden to prove the allegations in Charge III by a preponderance of the evidence, and the ALJ finds that the evidentiary record is therefore insufficient to conclude that Respondent violated 22 Texas Administrative Code § 217.11(1)(A), (1)(B), (1)(D), and § 217.12(1)(A), (1)(B), (4), (10)(C), and (11)(B).

Likewise, Staff's allegations under Charge IV also fail for a lack of evidence that Respondent misappropriated the Morphine or the Hydromorphone,[53] or failed to take precautions to prevent a misappropriation. The term "misappropriation" is not defined in the Board's rules or the Texas Nursing Practices Act, but Black's Law Dictionary defines the term as "[t]he application of another's property or money dishonestly to one's own use."[54] Applying this common meaning of the term to this record, there is no evidence that Respondent dishonestly used the two controlled substances for her own use or failed to take the necessary precautions to prevent such dishonest use of the medications. To speculate that a lack of documentation leads to a conclusion that Respondent acted wrongfully or dishonestly is unsupportable with this evidentiary record.

Nor is the ALJ inclined to make the evidentiary leap that because Respondent was once chemically dependent on Norco in 2001, she misappropriated Morphine in 2012. After voluntarily surrendering her license in 2001, the Board reinstated her license in 2002 in what Staff characterized as a "fairly arduous" and "unusual order." Respondent successfully completed TPAPN and produced negative drug screens for 5 years as required by the Board.[55]

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[52] Staff Ex. 4 at 6.

[53] As previously discussed, the evidence shows that Respondent appropriately administered the Hydromorphone to Patient No. 027503.

[54] Black's Law Dictionary (8th Ed. 2004).

[55] Resp. Ex. F.

According to Respondent, she has been clean and sober for 12 years, a statement partially corroborated by her negative drug screen in February 2012.[56] There is no evidence to support a conclusion that Respondent misappropriated or failed to take precautions to prevent the misappropriation of these two controlled substances. Accordingly, the ALJ concludes that Staff did not meet its burden to prove that Respondent violated 22 Texas Administrative Code § 217.12(1)(B), (6)(G), (8), and (11)(B).

C. Recommended Sanction

The Board has adopted a Disciplinary Matrix to govern the assessment of sanctions for violations of the Texas Occupations Code and the Board's rules and orders.[57] According to the Disciplinary Matrix, the Board may take more severe disciplinary action if the nurse is to be disciplined for multiple violations or had prior Board orders.

1. Staff's Position

Dr. Hester testified that Respondent's license should be revoked based on the 14 violations alleged in Staff's four charges. Dr. Hester applied the factors in 22 Texas Administrative Code § 213.33(c) to determine that, under the Disciplinary Matrix, the violations warrant a Second Tier, Level II sanction under both sections 301.452(b)(10) and 301.452(b)(13) of the Texas Occupations Code.

Dr. Hester stated that the violations present a serious risk of harm to the patients. For example, although Respondent pulled Morphine for Patient No. 601349 on January 21, 2011, at 0255 hours,[58] there is no documentation on the MAR or in the Nurses' Notes that the patient received that medication at that time. However, the MAR does indicate that the patient received a dose of Morphine at 0511 hours, 2 hours after Respondent pulled the Morphine. If the patient received the Morphine at 0255 hours and again at 0511 hours, then the patient received

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[56] Staff Ex. 7.

[57] 22 Tex. Admin. Code § 213.33(b).

[58] Staff Ex. 9 at 6.

Morphine in excess of what the physician prescribed. According to Dr. Hester, exceeding the dosage of Morphine could lead to depressed respiratory function, and this is an example of how dangerous it can be to fail to document the administration of a prescribed medication.[59]

In addition, Dr. Hester referred to Respondent's three prior Board orders as further justification for the revocation of Respondent's license.[60] Respondent agreed to findings of fact for the same violations alleged in this case: failure to document the administration of Morphine and Demerol; failure to document wastage; and the misappropriation of two controlled substances. Dr. Hester stated that 99% of the nurses licensed in Texas have no history of Board disciplinary action, yet Respondent has three prior Board orders for the same violations at issue in this proceeding.

2. Respondent's Position

Respondent has been a full-time nurse for the past 10 years,[61] and loved her job as a nurse in the ICU.[62] She was employed at Hermann Northwest for 8 years, and the hospital had taken no disciplinary actions against her before she was terminated.[63] She testified that she became addicted to pain medication following surgery, but that she has made a successful recovery[64] and has been clean and sober for the past 12 years, as shown by at least 5 years of clean drug screens under the 2002 Board reinstatement order.[65]

Respondent argues that assuming all of Staff's allegations are true, the facts only warrant a probated suspension. Also, there is no evidence that Respondent was impaired when she was practicing nursing, and the evidence, at most, only shows a failure to document what she did

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[59] *See* 22 Tex. Admin. Code § 213.33(c)(14).

[60] *See* 22 Tex. Admin. Code § 213.33(c)(6).

[61] Staff Ex. 5b at 3.

[62] Staff Ex. 5 at 3.

[63] Staff Ex. 5 at 3.

[64] Staff Ex. 5b at 3.

[65] Staff Ex. 5 at 4.

with the medications, according to Respondent. For this reason, Respondent contends that if Staff met its burden of proof, the violations would only warrant a Level I sanction of a warning with stipulations.

3. ALJ's Recommendation

Staff alleged that Respondent committed acts that would subject her to disciplinary action under section 301.452(b)(10) and (b)(13) of the Texas Occupations Code. Section 301.452(b)(10) authorizes disciplinary action for unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient. However, because Staff did not meet its burden to prove that Respondent's conduct was unprofessional under 22 Texas Administrative Code § 217.12, an analysis of the proper sanction for unprofessional conduct is not warranted in this proposal for decision.

The ALJ agrees with Staff that the violations represent a Second Tier offense due to the risk of patient harm. As Dr. Hester pointed out, Respondent pulled Morphine for Patient No. 601349 at 0255 hours on December 21, 2011,[66] and another nurse administered Morphine to this same patient 2 hours later, at 0511 hours.[67] The physician prescribed Morphine for this patient every 4 hours, but the ALJ cannot tell from this record whether this patient received the proper dosage. There could have been severe consequences if the patient had received two doses of Morphine within 2 hours. This demonstrates the risk of serious harm to a patient that is attributable to Respondent's failure to document.[68]

The ALJ also agrees with Staff that, after applying the factors in 22 Texas Administrative Code § 213.33(c), these violations warrant a Level II sanction. Respondent has two prior Board orders finding that she violated the Board's rules because she failed to document the administration of controlled substances.[69] Given her prior chemical dependency and disciplinary

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[66] Staff Ex. 9 at 6.

[67] Staff Ex. 12 at 82.

[68] 22 Tex. Admin. Code § 217.33(c)(1).

[69] 22 Tex. Admin. Code § 213.33(c)(6).

history, Respondent should have been cognizant of the importance of accurately and completely documenting whether controlled substances were administered to patients. In addition, as Dr. Hester testified, the patients in the ICU are very vulnerable and, in many instances, unable to communicate with their nurses. Therefore, it is imperative that Respondent accurately and completely document the administration of the Morphine and Hydromorphone for these patients so nurses on subsequent shifts can determine what has occurred.

However, the ALJ disagrees with Staff that revocation is warranted because there is no evidence of any actual misconduct by Respondent. Also, as Respondent testified, the ICU was chaotic, a new system had been installed, and she may have been acting as a charge nurse when she pulled the medications. In addition, Respondent testified that she tried to document the administration of Hydromorphone to Patient No. 027503, but was unable to access the system. For these reasons, the evidence shows that the practice setting may have contributed to the violations.[70] Furthermore, Respondent fully complied with what Dr. Hester characterized as a "fairly arduous" and "unusual" reinstatement order,[71] and there is no evidence of impairment, untrustworthiness, or lack of present fitness to practice.[72] Accordingly, the ALJ recommends that the Board suspend Respondent's license and that suspension be probated.

IV. SUMMARY

In sum, the ALJ finds that Respondent failed to maintain accurate and complete patient records, in violation of 22 Texas Administrative Code § 217.11(1)(D). By failing to comply with this Board rule regarding documentation, Respondent also violated 22 Texas Administrative Code § 217.11(1)(A) because her conduct did not conform to the Board's rules. For these violations, the ALJ recommends that the Board suspend Respondent's license, but probate that suspension.

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[70] 22 Tex. Admin. Code § 213.33(c)(12).

[71] 22 Tex. Admin. Code § 213.33(c)(6).

[72] 22 Tex. Admin. Code § 213.33(c)(2), (c)(4).

V. FINDINGS OF FACT

1. Sandra C. Lara (Respondent) is a registered nurse holding Permanent Certificate No. 616887 issued by the Texas Board of Nursing (Board).

2. Respondent has been practicing nursing for 10 years. Respondent was first licensed to practice in Texas on June 13, 1995.

3. Respondent was employed by Memorial Hermann Northwest Hospital (Hermann Northwest) during the time period of the alleged violations in Staff's Formal Charges.

4. On December 21, 2011, at 0255 hours, Respondent withdrew Morphine for Patient No. 601349 but did not document in the patient's records what Respondent did with the Morphine.

5. On December 26, 2011, at 0348 hours, Respondent withdrew Morphine for Patient No. 567501 but did not document in the patient's records what Respondent did with the Morphine.

6. On January 7, 2012, at 2142 hours, Respondent withdrew Morphine for Patient No. 327506 but did not document in the patient's records what Respondent did with the Morphine.

7. On January 8, 2012, at 0455 hours, Respondent withdrew Morphine for Patient No. 327506 but did not document in the patient's records what Respondent did with the Morphine.

8. On January 8, 2012, at 2136 hours, Respondent withdrew Morphine for Patient No. 327506 but did not document in the patient's records what Respondent did with the Morphine.

9. The records for Patient No. 027503 indicate that the patient was discharged and off unit on January 26, 2012, at 1811 hours. Although the patient's records indicate that the patient had been discharged, the patient was still physically in the hospital and had not yet been transferred to a long-term acute-care facility.

10. There was a valid physician's order prescribing Hydromorphone for Patient No. 027503.

11. On January 26, 2012, at 1939 hours, Patient No. 027503 was on an ambulance gurney but still physically located at Hermann Northwest. The patient was in pain and unattended by another nurse. Respondent withdrew Hydromorphone for Patient No. 027503 and administered the medication to the patient pursuant to the physician's order.

12. When Respondent attempted to document that she administered Hydromorphone to Patient No. 027503, she was unable to access the Hermann Northwest system because the patient had been technically discharged. Respondent did not take any other steps to

document the administration of Hydromorphone to Patient No. 027503 after she was unable to access the patient's records.

13. On January 26, 2012, at 1939 hours, Respondent withdrew Hydromorphone for Patient No. 027503 but did not document in the patient's records that Respondent administered the Hydromorphone to Patient No. 027503.

14. During the time period between December 2011 and January 2012, the Hermann Northwest ICU was a busy and chaotic unit. Hermann Northwest had installed a new patient record system that added to the chaos of the ICU. During this time, Respondent acted as a charge nurse and she may have pulled medications for other nurses to administer.

15. On July 22, 1999, the Board issued an agreed order finding that, in May of 1999, Respondent failed to document on 10 occasions the administration of Demerol and Morphine, she withdrew Demerol for one patient without a valid physician order, and she withdrew Morphine but did not document wastage. As a sanction, the Board imposed a Reprimand with Stipulations.

16. On August 1, 2001, the Board issued an agreed order finding that, in April of 2001, Respondent withdrew Demerol without a physician's order, she failed to document administering and wasting Demerol and Morphine, and she misappropriated Demerol. The 2001 Board order also contained a finding of fact that Respondent engaged in the intemperate use of Demerol. Pursuant to the 2001 Board order, Respondent voluntarily surrendered her license to practice nursing.

17. On October 24, 2002, the Board reinstated Respondent's license, and established Petitioner's date of sobriety as May 1, 2001. The Board required Respondent to complete the Texas Peer Assistance Program for Nurses and, after successful completion, submit to periodic drug screens during the 2-year stipulation period. Respondent was also required to attend substance-abuse support groups each week, in addition to other stipulations on her practice. Respondent successfully fulfilled the provisions of this order in March 2007.

18. Respondent had 5 years of negative drug screens taken in compliance with the October 23, 2002 Board order reinstating her license.

19. On February 1, 2012, Respondent consented to a drug screen. The results of that drug screen were negative for all substances tested, including opiates.

20. On August 2, 2013, Staff mailed to Respondent its Notice of Hearing with the Formal Charges attached.

21. The notice 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.

22. Administrative Law Judge Kerrie Jo Qualtrough convened the hearing on the merits on December 10, 2013, at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel John F. Legris represented Staff. Petitioner appeared and was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing on December 10, 2013.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction to govern the practice of nursing in Texas. Tex. Occ. Code ch. 301.

2. SOAH has jurisdiction to conduct formal hearings in matters involving alleged violations. Tex. Occ. Code § 301.459(a); Tex. Gov't Code ch. 2003.

3. The notice of the hearing met the requirements of Texas Occupations Code § 301.454, Texas Government Code §§ 2001.051 and 2001.052, and 1 Texas Administrative Code § 155.401.

4. A person is subject to disciplinary action for a violation of the Texas Occupations Code or a Board rule. Tex. Occ. Code § 301.452(b)(1).

5. A person is subject to disciplinary action for failing 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).

6. The Board has adopted standards that establish minimum levels of acceptable nursing practice. 22 Tex. Admin. Code § 217.11.

7. The Board's nursing standards require all nurses to accurately and completely report and document: the patient's status including signs and symptoms; nursing care rendered; physician orders; administration of medications and treatments; patient responses; and contacts with other health care team members concerning significant events regarding a patient's status. 22 Tex. Admin. Code § 217.11(1)(D).

8. Respondent failed to accurately and completely report and document the administration of medications to Patient Nos. 601349, 567501, 327506, and 027503. 22 Tex. Admin. Code § 217.11(1)(D).

9. The Board's nursing standards require all nurses to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations. 22 Tex. Admin. Code § 217.11(1)(A).

10. Respondent failed to conform to the Board's rules by failing to accurately and completely report and document the administration of controlled substances to Patient Nos. 601349, 567501, 327506, and 027503. 22 Tex. Admin. Code § 217.11(1)(A).

VII. RECOMMENDATION

The ALJ recommends that the Board suspend Respondent's license to practice nursing and that the suspension be probated.

SIGNED January 31, 2014.

KERRIE JO QUALTROUGH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS