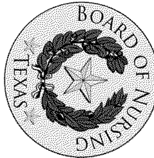


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

DOCKET NUMBER 507-15-2469

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 592601,	§	**OF**
ISSUED TO	§	
VALERIE ANN GREEN	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: VALERIE ANN GREEN
P.O. BOX 787
JACKSONVILLE, TX 75766

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

At the regularly scheduled public meeting on October 22-23, 2015, the Texas Board of Nursing (Board) considered the following items: (1) Order No. 1, *Dismissing Case,* issued by the ALJ in the above cited matter; (2) Staff's recommendation that the Board revoke the Respondent's registered nursing license by default; and (3) Respondent's recommendation to the Board regarding the above cited matter, if any.

On June 23, 2015, the ALJ convened a hearing on the merits in this matter. Staff of the Board was present for the hearing. However, the Respondent was not present at the hearing, and no one appeared on her behalf. During the hearing on June 23, 2015, Staff introduced evidence into the record demonstrating that Respondent had been sent a Notice of Hearing by first class certified mail return receipt requested to her last known address of record maintained by the Board in accordance with 22 Tex. Admin. Code §213.10(a). The ALJ found that Staff's notice was adequate and issued Order No. 1, *Dismissing Case*, granting Staff's Motion for Default and dismissing the case from the docket of SOAH and remanding it to the Board for informal disposition on a default basis in accordance with the Government Code §2001.056.

The Board, after review and due consideration of the Order No. 1, issued by the ALJ in the above cited matter, finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with the Government Code §2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Occupations Code Chapter 301 (Nursing Practice Act) for retention of Respondent's license to practice professional nursing in the State of Texas. The Board further finds that the Formal Charges were properly initiated and filed in accordance with the Occupations Code §301.458. The Board further finds that proper and timely notice regarding the violations alleged in the Formal Charges was given to Respondent in accordance with the requirements of the Government Code §2001.051 and §2001.052 and 1 Tex. Admin. Code §155.501. The Board further finds that the Respondent failed to appear in accordance with 22 Tex. Admin. Code Chapter 213 and 1 Tex. Admin. Code §155.501. As a result of the Respondent's failure to appear, the Board

has determined that the factual allegations listed in the Formal Charges are to be deemed admitted by default and the Board is authorized to enter a default order against the Respondent pursuant to the Government Code §2001.056 and 22 Tex. Admin. Code §213.22. Further, the Board has determined that it is entitled to revoke the Respondent's registered nursing license pursuant to 22 Tex. Admin. Code §213.33(m).

Therefore, the Board hereby adopts the factual allegations, which have been deemed admitted, and the conclusions of law contained in the Formal Charges, which are attached hereto and incorporated herein by reference for all purposes, and Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing in accordance with the Government Code Chapter 2001 and 22 Tex. Admin.Code §213.23(l), as applicable. All parties have a right to judicial review of this Order. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

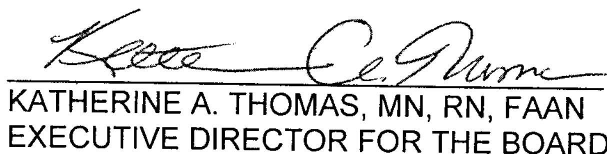
IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 592601, previously issued to VALERIE ANN GREEN, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure.

Entered this 22nd day of October, 2015.

TEXAS BOARD OF NURSING



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

Attachment: Formal Charges

In the Matter of **Permanent Registered Nurse** **License Number 592601** **Issued to VALERIE ANN GREEN,** **Respondent**	§ § § § §	**BEFORE THE TEXAS** **BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, VALERIE ANN GREEN, is a Registered Nurse holding License Number 592601, which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about April 19, 2014, Respondent failed to comply with the Order of the Board issued to her on April 18, 2013, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number One (1) of the Order which states, in pertinent part:

> (1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics....

A copy of the April 18, 2013, Order of the Board and Proposal for Decision is attached and incorporated, by reference, as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE II.

On or about April 19, 2014, Respondent failed to comply with the Order of the Board issued to her on April 18, 2013, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number Two (2) of the Order which states, in pertinent part:

> (2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE III.

On or about April 19, 2014, Respondent failed to comply with the Order of the Board issued to her on April 18, 2013, by the Texas Board of Nursing. Noncompliance is the result of her failure to comply with Stipulation Number Three (3) of the Order which states, in pertinent part:

> (3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills,"....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

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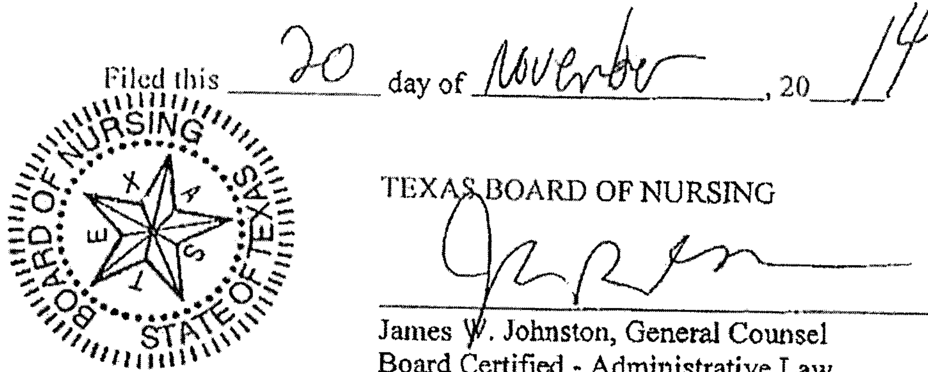
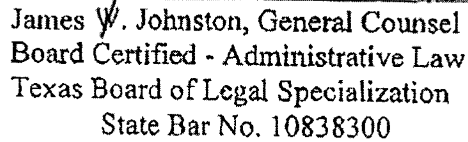
CONTINUED ON THE NEXT PAGE

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order dated April 18, 2013.



Filed this 20 day of November, 20 14

TEXAS BOARD OF NURSING

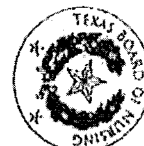


James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Natalie E. Adelaja, Assistant General Counsel
State Bar No. 24064715
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
John F. Legris, Assistant General Counsel
State Bar No. 00785533
John Vanderford, Assistant General Counsel
State Bar No. 24086670

333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Order of the Board dated April 18, 2013.

D/2014.08.18



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 507-13-1497

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 592601 ISSUED TO VALERIE ANN GREEN	§ § § § §	BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

OPINION AND ORDER OF THE BOARD

TO: VALERIE ANN GREEN
163 BOTHWELL
RUSK, TX 75785

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 18-19, 2013, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the registered nursing license of Valerie Ann Green 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. 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 generally agrees with the ALJ's recommendation that the

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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*

appropriate sanction in this matter is a Warning with Stipulations for one year. Additionally, the Board agrees, in general, with the ALJ's recommended stipulations, but does impose additional stipulations associated with a period of supervised and monitored practice to augment those recommended by the ALJ, as set out herein[2].

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 6 through 14 and Conclusions of Law Numbers 4 and 6 through 8, raises questions about her ability to practice nursing with reasonable skill and safety and calls into question her professional judgment. The Respondent failed to properly review and ensure the accuracy of patients' medical records and to detect the false information that was entered into the records by the LVN under her supervision[3]. In doing so, the Respondent failed to ensure a safe environment for the patients and permitted the creation of inaccurate medical records, which could have affected the subsequent care of the patients[4]. Further, the Respondent's falsification of the emergency medical transfer form reflects on the Respondent's professional character and ability to distinguish right from wrong[5].

Therefore, after reviewing the aggravating and mitigating factors in this matter[6], the Board finds that, pursuant to the Board's Disciplinary Matrix, the Board's Disciplinary Sanctions for Lying and Falsification, and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e) and (f), the Respondent's conduct warrants a Warning with Stipulations[7] for one year, to include a nursing jurisprudence and ethics course[8], a nursing documentation course, and a critical thinking course. The ALJ's recommended sanction includes remedial education courses, and the Board agrees that remedial education courses would be helpful in re-iterating the importance of ensuring accuracy in nursing documentation, as well as the duty of a nurse under the Nursing Practice Act and Board rules. Further, the Board finds that the Respondent's practice should be indirectly supervised for a period of one year. This stipulation was also recommended by the ALJ,

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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 finds that the Respondent's conduct, as set out in the PFD, collectively warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) and (13).

[3] See adopted Findings of Fact Numbers 10 through 14.

[4] See adopted Findings of Fact Numbers 12 through 14.

[5] See 22 Tex. Admin. Code §213.27.

[6] Respondent has no prior disciplinary history and the computer system was not working correctly that evening. See pages 6-7 of the PFD.

[7] Either a Warning with Stipulations or a Reprimand with Stipulations is warranted for a second tier, sanction level I sanction for a violation of §301.452(b)(10) and (13). Based on an evaluation of the aggravating and mitigating factors in this particular case, the Board finds that a Warning with Stipulations is more appropriate than a Reprimand with Stipulations.

[8] Pursuant to 22 Tex. Admin. Code §213.33(f), every disciplinary order issued by the Board shall require the individual to participate in a program of education or counseling prescribed by the Board, which at a minimum, shall include a review course in nursing jurisprudence and ethics.

and the Board agrees that the Respondent's practice should be indirectly monitored for a period of twelve months in order to ensure that the Respondent is appropriately assessing situations and making decisions that are in the best interests of her patients. The Board also finds that employment notification and quarterly employer reports should be submitted to the Board. These requirements will ensure that the Board remains informed about the Respondent's practice while under the terms of this Order and that the Respondent's practice is being supervised in accordance with the terms of this Order. Finally, the Board finds that the Respondent should be restricted from practicing in certain independent, autonomous, or unsupervised settings. These restrictions are necessary to ensure that indirect supervision is provided for the Respondent. Supervision 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. Finally, such restrictions are authorized under 22 Tex. Admin. Code §213.33(e) and are consistent with Board precedent and prior administrative decisions involving similar violations.

IT IS THEREFORE ORDERED, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER 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.*

IT IS FURTHER ORDERED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1)YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(5) 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.

(6) While under the terms of this Order, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year(s) of employment as a nurse.

IT IS FURTHER 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 shall be eligible for nurse licensure compact privileges, if any.

Entered this 18th day of April, 2013.

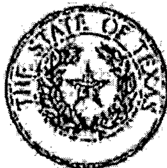
TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-13-1497 (February 11, 2013).

Upload Date: 20130211112953 Account Number: 13 Upload Description: 13-1497PFD

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

February 11, 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

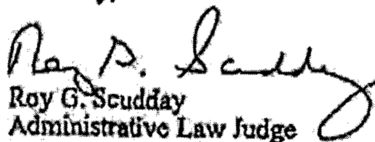
RE: Docket No. 507-13-1497; Texas Board of Nursing v. Valerie A. Green

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,



Roy G. Scudday
Administrative Law Judge

RGS/ap
Enclosures
XC: Lance Brenton, 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) – VIA INTERAGENCY
Valerie Ann Green, 163 Bothwell, Rusk, TX 75785 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-13-1497

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
VALERIE ANN GREEN, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought action against Valerie Ann Green (Respondent) seeking sanctions against her license. This proposal for decision finds that Respondent should be issued a warning to last for a period of one year with indirect supervision and required to take remedial education.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Matters concerning notice and jurisdiction were undisputed. Those matters are set out in the Findings of Fact and Conclusions of Law.

The hearing convened January 29, 2013, before Administrative Law Judge (ALJ) Roy G. Scudday in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by Lance R. Brenton, Assistant General Counsel. Respondent appeared on her own behalf. The record closed at the conclusion of the hearing.

II. DISCUSSION

A. Background

Respondent was licensed in Texas as a Registered Nurse (RN) on August 10, 1993. On August 21, 2012, Staff sent Respondent a Notice of Formal Charges filed against her. On December 14, 2012, Staff sent Respondent a Notice of Hearing.

B. Staff's Charges

Staff made the following charges against Respondent:

1. On or about July 1-2, 2010, while employed with University of Texas Medical Branch-Correctional Managed Care (UTMB-CMC), Galveston, Texas, and assigned to Texas Department of Criminal Justice (TDCJ), Skyview Unit, Rusk, Texas, Respondent failed to document her signature on patient care Electronic Medical Record email notifications. Respondent's conduct resulted in incomplete medical records and was likely to injure the patients in that she would be missing vital information regarding patient care and updates. This action constitutes grounds for disciplinary action in accordance with Texas Occupations Code (Code) § 301.452(b)(10) and (13), and is a violation of 22 Texas Administrative Code (TAC) § 217.11(1)(A), (1)(B) & (1)(D) and 22 TAC 217.12(1)(B) and (1)(C).

2. On or about July 1-2, 2010, while employed with UTMB-CMC, Galveston, Texas, and assigned to TDCJ, Skyview Unit, Rusk, Texas, Respondent failed to sign the patient care documentation completed on her behalf by a staff Licensed Vocational Nurse (LVN) regarding two new patients, TDCJ Numbers 1647489 and 345158, after Respondent reviewed the LVN's documentation for accuracy. As a result, Respondent did not detect and possibly correct false documentation by the LVN indicating that orders had been received from the Physician's Assistant (PA) to transfer the patients to a local emergency room (ER) for evaluation. Neither Respondent nor the LVN actually spoke with or received orders from the PA. Respondent's conduct resulted in inaccurate medical records and was likely to deceive subsequent care givers who relied on the information while providing care to the patients. This action constitutes grounds for disciplinary action in accordance with Code § 301.452(b)(10) and (13), and is a violation of 22 TAC § 217.11(1)(A), (1)(D) & (1)(U) and 22 TAC § 217.12(1)(A), (1)(C) and (1)(F).

3. On or about July 1-2, 2010, while employed with UTMB-CMC, Galveston, Texas, and assigned to TDCJ, Skyview Unit, Rusk, Texas, Respondent falsely documented on the Emergency Medical Transfer form of Patient TDCJ Numbers 1647489 that PA "B. Lofton" was the physician who sent the patient out to be evaluated when PA Lofton had not been in communication with either Respondent or the LVN who was also present during the shift. Respondent's conduct resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the information while providing care to the patients. This action constitutes grounds for disciplinary action in accordance with § 301.452(b)(10) and

(13), and is a violation of 22 TAC §§ 217.11(1)(A) & (1)(D), and 22 TAC § 217.12(1)(A), (1(B), (1)(C), (6)(A) and (6)(H).

C. Applicable law

Code § 301.452 provides as follows:

(b) A person is subject to denial of a license or to disciplinary action under this subchapter for:

. . . .

(10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public;

. . . .

(13) 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.

The applicable Board rules are as follows:

22 Tex. Admin. Code § 217.11. Standards of Nursing Practice.

. . . .

(1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:

(A) 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;

(B) Implement measures to promote a safe environment for clients and others;

(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same;

(D) 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;

. . . .

(U) Supervise nursing care provided by others for whom the nurse is professionally responsible; . . . .

22 Tex. Admin. Code § 217.12. Unprofessional Conduct.

. . . .

(1) Unsafe Practice--actions or conduct including, but not limited to:

(A) 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.

(B) Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;

(C) Improper management of client records;

. . . .

(F) Failing to supervise the performance of tasks by any individual working pursuant to the nurse's delegation or assignment; . . . .

. . . .

(6) Misconduct--actions or conduct that include, but are not limited to:

(A) Falsifying reports, client documentation, agency records or other documents;

. . . .

(H) Providing information which was false, deceptive, or misleading in connection with the practice of nursing; . . . .

D. Evidence

1. Undisputed Facts

In July 2010, Respondent was an employee of UTMB-CMC assigned to the TDCJ Skyview Unit in Rusk, Texas. Although her primary responsibility was for Crisis Management Care, on July 1, 2010, she was assigned to the Unit ER. At 7:56 p.m. patient TDCJ Number 1647489 was brought into the ER in a wheelchair. Respondent performed an assessment of his condition and observed that he had an elevated heart rate (135-154), was unable to ambulate, was incontinent, was unable to sit upright in the wheelchair, and had general weakness, gray skin

color, fair turgor, PEARLA[1], dry and pale mucus membranes, and a weak bilateral grip. Respondent dictated her assessment to LVN Whitten, who entered the data into the computer. Both Respondent and Ms. Whitten attempted to contact PA Robert Lofton, the PA on call, but were unable to do so. Respondent then contacted the UTMB Utilization Team in Galveston who gave her authorization to have the patient transferred to a local ER for evaluation/crisis management. The patient was then transferred to Jacksonville ETMC.[2]

At 8:00 p.m. patient TDCJ Number 345158 was brought into the ER. Respondent performed an assessment of his condition and observed that he had an elevated blood pressure (197/112 and 232/111), and was alert, but had not taken his blood pressure medicine recently. Respondent dictated her assessment to LVN Whitten, who attempted to enter the data into the computer, which was undergoing a series of disruptions. As a result, the emergency record was reduced to writing and accompanied the patient to the local ER. Both Respondent and Ms. Whitten again attempted to contact PA Lofton, but were unable to do so. Respondent again contacted the UTMB Utilization Team in Galveston who gave her authorization to have the patient transferred to a local ER for crisis management. The patient was then transferred to Jacksonville ETMC.[3]

2. Respondent's Testimony

Respondent testified that July 1, 2010, was the first time that she had been assigned to the Unit ER. She stated that the Unit protocol as explained to her by her supervisor was to attempt to contact the physician or PA to authorize a patient transfer to a local ER. If she was unable to contact someone, instead of calling 911 as set forth in the UTMB policy,[4] she was instructed to contact the UTMB Utilization Team for authorization, with which no physician order was necessary.

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[1] Pupils Equal and React to Light and Accommodation.

[2] Staff Ex. 7, pp. 4-6.

[3] Staff Ex. 8, pp. 16-18.

[4] Staff Ex. 6, p. 36.

Respondent testified that even though she followed the Unit protocol with the two patients, at some point after she had reviewed the records entered by Ms. Whitten and determined that they were correct, Ms. Whitten amended the records without her knowledge to reflect that PA Lofton had been notified and ordered the transfers. Respondent stated that, because the computers had gone down, she did not again review the records until sent to her by email within twenty-four hours of the incidents, at which time she electronically signed them without noticing the change. However, she could not explain why the records did not reflect her electronic signature, and pointed out that she had received no training regarding the electronic signing of emails.

Respondent testified that, in order to have security allow the transfer of a prisoner to a local ER, the written Emergency Medical Transfer form that was separate from the computer records required the name of the sending physician. Because she had not been able to contact PA Lofton, Respondent admitted putting his name on the form[5] in order to effect the transfer of patient TDCJ Number 1647489 because she felt that the failure to do so could prove to be life-threatening to the patient.

3. Ramona Gaston McNutt's Testimony

Staff offered the testimony of Ramona Gaston McNutt, who has been a Board Nursing Consultant for Practice since 2012. Ms. McNutt has been a Registered Nurse for almost 20 years with experience in diverse areas including direct care, nurse administration, and regulation. As a Nurse Practice Consultant for the Board, Ms. McNutt assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in State Office of Administrative Hearings (SOAH) hearings.

Ms. McNutt testified that a nurse should either enter the data of her assessment herself or otherwise ensure its accuracy. She stated that a copy of any written records should have been

[5] Staff Ex. 7, p. 29.

kept at the Unit. She testified that, rather than entering PA Lofton's name on the transfer form, Respondent should have clarified who had authorized the transfer or called 911 instead.

The Disciplinary Matrix of the Board at 22 TAC § 213.33(b) provides that discipline for unprofessional or dishonorable conduct that is likely to injure a patient pursuant to Code § 301.452(b)(10) and for failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm pursuant to Code § 301.452(b)(13) will be determined based on the seriousness of the offense. Ms. McNutt testified that, due to the aggravating factor that two patients were involved, the offenses should be considered Second Tier Offenses. She also stated that, in view of the mitigating factors of a computer failure and that Respondent has no other incidents that question her competence, Sanction Level I would be appropriate. That sanction level for the alleged violations calls for a Warning or Reprimand with Stipulations that may include supervised practice.

E. Analysis

Charge I. Staff alleges that by failing to electronically sign the two emergency records, Respondent violated 22 TAC § 217.12(1)(B) and (1)(C). Staff asserts that this failure resulted in incomplete medical records and was likely to injure the patients in that the records would be missing vital information regarding patient care and updates.

It is not clear whether Respondent unsuccessfully attempted to sign the emails or did not sign them, but it is clear that without her signature the records were not complete. In either case the result was an improper management of client records in violation of 22 TAC § 217.12 (1)(B) and (C).

Charge II. Staff alleges that Respondent's failure to detect and correct the false documentation by the LVN indicating that orders had been received from the PA to transfer the patients to a local ER for evaluation violated 22 TAC § 217.11(1)(A), (1)(D) and (1)(U) and 22 TAC § 217.12(1)(A), (1)(C) and (1)(F). Staff asserts that this failure resulted in inaccurate

medical records and was likely to deceive subsequent care givers who relied on the information while providing care to the patients.

It is not disputed that the records falsely indicated that PA Lofton had authorized the transfers. Respondent stated that she apparently overlooked the inclusion of the entry by Ms. Whitten that was not present when she first reviewed the report. By failing to note the false entry Respondent failed to adequately supervise the data entry by the LVN, resulting in improper management of and inaccurate medical records for two patients, in violation of 22 TAC § 217.11(1)(A), (1)(D) and (1)(U) and 22 TAC § 217.12(1)(A), (1)(C) and (1)(F).

Charge III. Staff alleges that Respondent's falsely documenting the Emergency Medical Transfer form of Patient TDCJ Number 1647489 violated 22 TAC §§ 217.11(1)(A) and (1)(D), and 22 TAC § 217.12(1)(A), (1)(B), (1)(C), (6)(A) and (6)(H). Staff asserts that this failure resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the information while providing care to the patient.

Despite Respondent's intentions, it is clear that she deliberately created a false record by indicating on the separate transfer form that PA Lofton had authorized the transfer of patient TDCJ Number 1647489 instead of clarifying the true source of the transfer authorization. Such action resulted in an inaccurate medical record and was likely to deceive subsequent care givers who relied on the information that a PA had authorized the transfer. As a result, Respondent violated 22 TAC §§ 217.11(1)(A) and (1)(D), and 22 TAC § 217.12(1)(A), (1)(B), (1)(C), (6)(A) and (6)(H).

Sanction. Staff argues that the appropriate sanction in this case, according to the Disciplinary Matrix, is a Warning to last for a period of one year, remedial education, and indirect supervision. The remedial education requirement should enable Respondent to know the importance of ensuring the accuracy of medical records, and how to fill out forms that do not appear to allow for an accurate indication of a situation. The indirect supervision requirement should provide appropriate monitoring of Respondent to ensure that her records are accurate and complete. Accordingly, the ALJ agrees with Staff's recommendation.

III. FINDINGS OF FACT

1. Valerie Ann Green (Respondent) has been licensed as a registered nurse by the Texas Board of Nursing (Board) since 1993.

2. On August 21, 2012, the Board's Staff (Staff) sent Respondent a Notice of Formal Charges filed against her.

3. On December 14, 2012, Staff mailed a Notice of Hearing to Respondent.

4. 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.

5. The hearing convened January 29, 2013, in the William P. Clements Building, 300 West 15th Street, Austin, Texas.

6. In July 2010, Respondent was an employee of the University of Texas Medical Branch-Correctional Managed Care (UTMB-CMC), Galveston, Texas, and assigned to the Texas Department of Criminal Justice (TDCJ), Skyview Unit, Rusk, Texas. Her primary responsibility was for Crisis Management Care.

7. On July 1, 2010, Respondent was assigned to the Unit Emergency Room (ER).

8. At 7:56 p.m. on that date patient TDCJ Number 1647489 was brought into the ER in a wheelchair. Respondent performed an assessment of his condition. Respondent dictated her assessment to LVN Whitten, who entered the data into the computer, which Respondent checked for accuracy. Both Respondent and Ms. Whitten attempted to contact Physician Assistant (PA) Robert Lofton, the PA on call, but were unable to do so. Respondent then contacted the UTMB Utilization Team in Galveston, who gave her authorization to have the patient transferred to a local ER for evaluation/crisis management. The patient was then transferred to Jacksonville ETMC.

9. At 8:00 p.m. on that same date patient TDCJ Number 345158 was brought into the ER. Respondent performed an assessment of his condition. Respondent dictated her assessment to LVN Whitten, who attempted to enter the data into the computer, which was undergoing a series of disruptions. As a result, the emergency record was reduced to writing and accompanied the patient to the local ER. Both Respondent and Ms. Whitten attempted to contact PA Lofton but were unable to do so. Respondent then contacted the UTMB Utilization Team in Galveston, who gave her authorization to have the patient transferred to a local ER for crisis management. The patient was then transferred to Jacksonville ETMC.

10. At some point after Respondent had reviewed the records entered by Ms. Whitten and determined that they were correct, Ms. Whitten amended the records without Respondent's knowledge to reflect that PA Lofton had been notified and ordered the transfers. Respondent did not again review the records until sent to her by email within twenty-four hours of the incidents and Respondent failed to notice the change. The records did not reflect her electronic signature.

11. In order to have security allow the transfer of a prisoner to a local ER, the written Emergency Medical Transfer form, which is separate from the computer records, required the name of the sending physician. Because Respondent had not been able to contact PA Lofton, she put PA Lofton's name on the form in order to effect the transfer of patient TDCJ Number 1647489 because she felt that the failure to do so could prove to be life-threatening to the patient.

12. The failure to ensure that her electronic signature was on the computerized medical records is a failure to implement measures to promote a safe environment for clients and indicate knowledge of the rationale for and the effects of treatments and the correct administration of the same.

13. The failure to ensure that the computerized medical records were accurate and complete is a failure to conform to the Board's rules and regulations, to accurately and completely report and document physician orders, to supervise nursing care by others for whom Respondent was professionally responsible, to carefully perform registered nursing in conformity with the standards of minimum acceptable level of nursing practice, to properly manage client records, and to supervise the performance of tasks by an individual working pursuant to Respondent's delegation.

14. The false entering of a PA's name on a transfer order is a failure to conform to the Board's rules and regulations, to accurately and completely report and document physician orders, to carefully perform registered nursing in conformity with the standards of minimum acceptable level of nursing practice, to conform to generally accepted nursing standards in applicable practice settings, to properly manage client records, and falsified client documentation and provided information which was false, deceptive, or misleading in connection with the practice of nursing.

IV. CONCLUSIONS OF LAW

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

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

3. Notice of the hearing on the merits was provided. Code § 301.454 and Tex. Gov't Code §§ 2001.051 and 2001.052.

4. Respondent is subject to disciplinary action by the Board. Code § 301.452(b)(10) and (13).

5. Staff had the burden of proof by a preponderance of the evidence.

6. Based on Findings of Fact Nos. 8, 9, and 12, it is concluded that Respondent violated 22 Tex. Admin. Code (TAC) § 217.12(1)(B) and (1)(C).

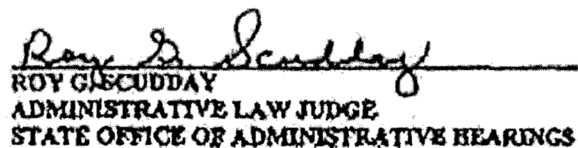
7. Based on Findings of Fact Nos. 8-10, and 13, it is concluded that Respondent violated 22 TAC § 217.11(1)(A), (1)(D) and (1)(U) and 22 TAC § 217.12(1)(A), (1)(C) and (1)(F).

8. Based on Finding of Fact No. 11 and 14, it is concluded that Respondent violated 22 TAC §§ 217.11(1)(A) and (1)(D), and 22 TAC § 217.12(1)(A), (1)(B), (1)(C), (6)(A) and (6)(H).

V. RECOMMENDATION

Based upon the above findings of fact and conclusions of law, the ALJ recommends that Respondent be issued a warning for a period of one year with indirect supervision and required to take remedial education.

SIGNED February 11, 2013.



ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS