DOCKET NUMBER 507-17-0104

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
REGISTERED NURSE	§	
LICENSE NUMBER 719413,	§	**OF**
ISSUED TO	§	
CYNTHIA WILLIAMS	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: CYNTHIA WILLIAMS
7618 BRIDENWOOD CT.
SPRING, TX 77379

SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 20-21, 2017, 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 without changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

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

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

Recommendation for Sanction

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

[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

this matter is a Warning with Stipulations[2].

The ALJ found, and the Board agrees, that the Respondent's medication error warrants a second tier, sanction level I sanction[3]. For a second tier, sanction level I sanction for a violation of §301.452(b)(10) and (13), the Board's Disciplinary Matrix[4] collectively authorizes a Warning or Reprimand with Stipulations. For Respondent's charting error, the ALJ found, and the Board agrees, that a first tier, sanction level I sanction is warranted[5]. For a first tier, sanction level I sanction for a violation of §301.452(b)(10) and (13), the Board's Disciplinary Matrix authorizes remedial education.

In determining the appropriate sanction in this case, the Board must consider the aggravating and mitigating factors. The Respondent's conduct in failing to administer the potassium phosphate placed the patient at a risk of harm, namely organ damage[6]. However, no actual harm occurred as a result of the Respondent's omission[7]. Further, while the Respondent incorrectly documented in a patient's chart, the charting error caused no harm or risk of harm to the patient[8]. Additionally, the Respondent has no prior disciplinary history with the Board and there is no evidence of a lack of truthfulness or trustworthiness[9].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[10] and the Board's rules, including 22 Tex. Admin. Code §213.33(e), that the Respondent's nursing license should be subject to a Warning with Stipulations. However, the Board agrees with the ALJ[11], that given that the Respondent's errors occurred on a single day over five years ago in an otherwise unblemished career, that the stipulations should only

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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] See pages 8-10 and 12 of the PFD.

[3] See pages 8-9 of the PFD.

[4] 22 Tex. Admin. Code §213.33(b).

[5] See page 9 of the PFD.

[6] See adopted Finding of Fact Number 11.

[7] See adopted Finding of Fact Number 12.

[8] See adopted Findings of Fact Numbers 13-14.

[9] See adopted Findings of Fact Numbers 15-16.

[10] 22 Tex. Admin. Code §213.33(b).

[11] See page 9 of the PFD.

consist of remedial education courses[12], instead of the work restrictions typically associated with a Warning with Stipulations[13].

IT IS THEREFORE ORDERED, that RESPONDENT SHALL receive the sanction of **WARNING WITH STIPULATIONS** in accordance with the terms of this Order.

A. This Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

B. This Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

I. COMPLIANCE WITH LAW

While under the terms of this Order, 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.

II. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that 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. Home study courses and video programs will not be approved.

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[12] See 22 Tex. Admin .Code §213.33(e)(3) and (f).

[13] A Warning with Stipulations typically includes supervised practice for a period of at least one year. See 22 Tex. Admin. Code §213.33(e)(3).

B. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

C. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: 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. Home study courses and video programs will not be approved.

D. **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/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

III. RESTORATION OF UNENCUMBERED LICENSE(S)

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 20th day of April, 2017.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-17-0104 (January 24, 2017).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

January 24, 2017

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

VIA INTERAGENCY

RE: Docket No. 507-17-0104; Texas Board of Nursing v. Cynthia Williams

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.texas.gov.

Sincerely,

Shannon Kilgore
Administrative Law Judge

SK/tt
Enclosures

xc: R. Kyle Hensley, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – VIA INTERAGENCY
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX – VIA INTERAGENCY
Cynthia Williams, 7618 Bridenwood Ct., Spring, TX 77379 - VIA REGULAR MAIL

SOAH DOCKET NO. 507-17-0104

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
CYNTHIA V. WILLIAMS, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) brought this disciplinary action against registered nurse (RN) Cynthia V. Williams, alleging that she (a) slept while on duty; (b) failed to administer a medication ordered by a physician; and (c) inaccurately charted that a patient was incontinent and catheterized. After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds that the evidence establishes two of Staff's claims—that Ms. Williams failed to administer an ordered medication and made a minor error in a medical record. The evidence does not substantiate that Ms. Williams was unavailable to her patients due to sleeping on duty. The ALJ recommends that she be issued a warning with probationary stipulations.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion.

The hearing convened on December 13, 2016, before ALJ Shannon Kilgore at the hearings facility of the State Office of Administrative Hearings (SOAH) in Austin, Texas. Staff was represented by Kyle Hensley, Assistant General Counsel. Ms. Williams represented herself. The record closed the same day.

II. APPLICABLE LAW

Under the Nursing Practice Act (Act), a nurse is subject to disciplinary action for engaging in "unprofessional or dishonorable conduct that, in the [B]oard's opinion, is likely to deceive, defraud, or injure a patient or the public."[1] The Board's rules define "unprofessional conduct" to include the following behaviors:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform registered 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]
- Improperly managing client records;[4]
- Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care;[5]
- Engaging in careless or repetitive conduct that may endanger a client's life, health, or safety, regardless of whether actual injury to a client is established;[6]
- Demonstrating actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition;[7]
- Falsifying reports, client documentation, agency records or other documents;[8] and
- Providing information that was false, deceptive, or misleading in connection with the practice of nursing.[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(1)(C).

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

[6] 22 Tex. Admin. Code § 217.12(4).

[7] 22 Tex. Admin. Code § 217.12(5).

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

A nurse is also subject to sanction for a lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public.[10]

The Board is further authorized to take disciplinary action against a nurse for her "failure to care adequately for a patient or to adequately conform to the minimum standards of acceptable nursing practice in a manner that, in the [B]oard's opinion, exposes a patient or other person unnecessarily to risk of harm."[11] By Board rule, minimum standards of nursing practice require all nurses to know and conform to the Act and Board rules,[12] to "know the rationale for and the effects of medications and treatments and . . . correctly administer the same;"[13] to "[a]ccurately and completely report and document: (i) the client's status including signs and symptoms; [and] (ii) nursing care rendered,"[14] and to "[i]nstitute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications."[15]

When a nurse has violated the Act or related Board rules, the Board is required to impose a disciplinary sanction, which can range from the issuance of a written warning to revocation of the nurse's license.[16] When a nurse receives a warning or reprimand, the Board is also authorized to impose probationary stipulations, which may require increased workplace supervision and additional education.[17] To guide the determination of an appropriate sanction, the Board has adopted a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[18] The Disciplinary Matrix categorizes offenses into several tiers, with two

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[9] 22 Tex. Admin. Code § 217.12(6)(H).

[10] Tex. Occ. Code § 301.452(b)(12).

[11] Tex. Occ. Code § 301.452(b)(13).

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

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

[14] 22 Tex. Admin. Code § 217.11(1)(D).

[15] 22 Tex. Admin. Code § 217.11(1)(M).

[16] Tex. Occ. Code § 301.453(a); 22 Tex. Admin. Code § 213.33(e).

[17] 22 Tex. Admin. Code § 213.33(e)(3)-(4).

[18] 22 Tex. Admin. Code § 213.33(a).

sanction levels each. The tier level is based upon the nature and seriousness of the offense, while the sanction level within each tier is determined by considering certain aggravating and mitigating factors listed in the Disciplinary Matrix and in Board Rule 213.33(c).[19]

III. DISCUSSION

A. Background

Staff's case-in-chief consisted of eight exhibits and the testimony of two witnesses: Jill Rene Tackett, RN and Denise Benbow, MSN, RN. Ms. Williams testified on her own behalf. Staff re-called Ms. Benbow as a rebuttal witness.

This case involves a single 7:00 p.m.-to-7:00 a.m. night shift, on July 30, 2011, at St. Luke's Hospital at The Village (St. Luke's) in Houston, Texas. Ms. Williams was assigned to the intensive care unit (ICU) during that shift.[20] The allegations concerning patient care and charting involve the same patient (Patient).

B. Charge I: Alleged Sleeping

Staff's Formal Charges allege:

> On or about July 30, 2011, while employed as a Registered Nurse, and on the night shift at St. Luke's Hospital at The Village, Houston, Texas, Respondent lacked fitness to practice nursing in that she was observed sleeping while on duty. Respondent's conduct could have affected her ability to recognize subtle signs, symptoms or changes patients' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.

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[19] 22 Tex. Admin. Code § 213.33(b), (c).

[20] Staff Ex. 5 at 69.

In support of this allegation, Staff offered the testimony of Ms. Tackett, another nurse in the ICU on the same shift. Ms. Tackett stated that she observed Ms. Williams from behind while Ms. Williams was sitting at a computer, charting. According to Ms. Tackett, Ms. Williams was struggling to stay awake, nodding off and then catching herself. She almost fell out of her chair but did not fall. She did not sleep more than one to two minutes. Ms. Williams testified that she did not sleep on the job and that Ms. Tackett was hostile to her.

Ms. Tackett's testimony described a nurse who may have experienced a period of sleepiness while charting and struggled to stay awake, nodding off a few times but remaining upright and working—not a nurse who was sleeping and unable to respond to the demands of her job. This evidence does not establish, as urged by Staff, that Ms. Williams: exhibited an inability to perform registered nursing in conformity with the standards of minimum acceptable level of nursing practice; carelessly or repeatedly failed to conform to generally accepted nursing standards in applicable practice settings; accepted the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could reasonably have been expected to result in unsafe or ineffective client care; engaged in careless or repetitive conduct that may have endangered a client's life, health, or safety; or demonstrated actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition. Accordingly, Staff has failed to prove this basis for sanction.

C. Charge II: Alleged Failure to Administer a Medication

Staff's Formal Charges allege:

> On or about July 30, 2011, while employed as a Registered Nurse, and on the night shift at St. Luke's Hospital at The Village, Houston, Texas, Respondent failed to follow the Diabetic Ketoacidosis (DKA) protocol for Patient Medical Record Number 2958572, in that after it was reported that the patient had a low phosphorous level of 1.6, Respondent failed to administer Potassium phosphate, as ordered by the physician. Respondent's conduct delayed the onset of medical care needed to stabilize the patient and prevent further complications, and may have contributed to the patient's extended hospital stay.

The evidence establishes that Ms. Williams should have administered both potassium chloride and potassium phosphate, but only administered potassium chloride. Patient was hospitalized for DKA.[21] Patient's chart includes standing orders titled, "DKA in Adults Physician Orders."[22] These standing orders provided for the administration of medications should a patient's lab values for potassium or phosphorous fall below identified levels. For a phosphate (PO4) blood level at certain low values, potassium phosphate was to be administered in specific amounts.[23] For a potassium (K) blood level at certain low values, potassium chloride was to be administered in specific amounts.[24] On July 30, 2011, Patient's lab values (phosphorus at 1.9 milligrams per deciliter and potassium at 3.8 milliequivalent per liter)[25] met the criteria under the standing orders. A handwritten order in Patient's chart from 18:45 p.m. on July 30, 2011, reflected that both potassium chloride (KCL) and potassium phosphate were to be administered due to the lab values.[26]

Ms. Benbow testified that the triggering lab values were recognized at 18:45, which was just 15 minutes before the end of the day shift, and the medications were not administered by the day shift nurse, so the task fell to Ms. Williams. Ms. Williams argued that the lab values should have triggered administration of the appropriate medications during the day shift.[27] She testified that she came in for her shift early and was even the person who noticed the lab report and recognized the need to administer medication, and that she did properly administer the necessary

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[21] Staff Ex. 6 at 12.

[22] Staff Ex. 6 at 27-28.

[23] Staff Ex. 6 at 28.

[24] Staff Ex. 6 at 28.

[25] Staff Ex. 6 at 12. The low phosphorus value alleged in Staff's Formal Charges, "1.6," is incorrect.

[26] Staff Ex. 6 at 30.

[27] Ms. Williams pointed to the time of 15:55 on the lab sheet. Staff Ex. 6 at 12. However, as noted by Ms. Benbow, this time may have related to the blood draw, not the analysis results. And, it was Ms. Williams who administered the potassium chloride, so it would be illogical to conclude she was not responsible for the administration of the potassium phosphate as well.

medication. She pointed out that she signed below the handwritten order,[28] indicating that she had carried it out.

Patient's chart reflects that Ms. Williams did sign below the handwritten order for potassium chloride and potassium phosphate. And, the medication administration record in the chart reflects that Ms. Williams properly administered the potassium chloride.[29] The medication administration record does not, however, reflect that she administered the potassium phosphate.[30]

Ms. Benbow testified that the failure to give needed medication to an acidotic patient created the potential for harm in the form of organ damage.

The ALJ determines that the evidence demonstrates Ms. Williams failed to administer the ordered potassium phosphate, which also constituted failure to institute appropriate nursing interventions that might be required to stabilize a client's condition or prevent complications, careless failure to conform to generally accepted nursing standards, and careless conduct that may have endangered a client's health. She is subject to sanction under Texas Occupations Code § 301.452(b)(10) and (13), and Board Rules 217.11(1)(C) and (M) and 217.12(1)(A) and (4).

D. Charge III: Alleged Documentation Error

Staff's Formal Charges allege:

> On or about July 30, 2011, while employed as a Registered Nurse, and on the night shift at St. Luke's Hospital at The Village, Houston, Texas, Respondent incorrectly documented that Patient Medical Record Number 2958572 was incontinent, and had a foley catheter and a suprapubic catheter. The patient was neither incontinent, nor did she have catheters in place. Respondent's conduct created an inaccurate medical record.

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[28] Staff Ex. 6 at 30.

[29] Staff Ex. 6 at 46.

[30] Staff Ex. 6 at 47. In addition, the flow sheet reflected the administration of the potassium chloride, but not the potassium phosphate, by Ms. Williams on July 30, 2011. Staff Ex. 6 at 74-75.

Patient's chart reflects entries by Ms. Williams that Patient was incontinent and had foley and suprapubic catheters.[31] However, Ms. Benbow testified that Patient's history and physical made no mention of a catheter and other entries in Patient's chart indicate that she was continent and had no catheters.[32] Ms. Williams did not dispute that she may have clicked the wrong box to indicate, incorrectly, that the patient was catheterized. She emphasized that she is a detail-oriented charter who was adjusting to a new digital system. She stated that, at St. Luke's, a nurse had 24 hours to correct an error in charting but she was sent home and fired after being reported by Ms. Tackett for sleeping. Consequently, said Ms. Williams, she had no opportunity to correct her mistake. Ms. Benbow stated that nurses are responsible for creating an accurate medical record, but also acknowledged that these kinds of errors sometimes happen with digital systems and said that there was no harm from the error.

Staff established that Ms. Williams made a minor, inadvertent error in charting. In making this error, Ms. Williams carelessly failed to meet standards of minimum acceptable level of nursing practice, did not accurately document the patient's status, and provided misleading information. She is subject to sanction under Texas Occupations Code § 301.452(b)(10) and (13), and Board Rules 217.11(1)(D) and 217.12(1)(A) and (6)(H). Staff failed to show that Ms. Williams improperly managed client records; engaged in careless or repetitive conduct that may have endangered a client's life, health, or safety; or falsified client documentation.

E. Sanctions

Ms. Benbow analyzed all three alleged violations as falling within Tier 2, Sanction Level 1 in the Board's Disciplinary Matrix.

As discussed above, the first allegation—sleeping on the job and thereby being potentially unresponsive to patients—was not proven. The ALJ agrees with Ms. Benbow that the medication administration error is properly classified as Tier 2, in that it resulted in a serious risk

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[31] Staff Ex. 6 at 121.

[32] *See, e.g.*, Staff Ex. 6 at 82-83, 85, 87 (urine void entries).

to the condition of a vulnerable ICU patient. However, there are a number of mitigating circumstances. Chief among them is the fact that this error occurred over five years ago in a career with no other disciplinary issues. Ms. Williams has been licensed since 2005. She testified that she has been an ICU nurse for 10 years, is a certified critical care nurse, and engages in detail-oriented practice. No actual patient harm was shown. There is no evidence of a lack of truthfulness or trustworthiness. Therefore, the ALJ agrees with Ms. Benbow that Sanction Level 1 is appropriate.

As to the charting error, the evidence indicates that this was even less than a Tier 1 offense because the evidence shows no identified unsafe practice or any risk of patient harm from the incorrect entry in the patient's chart that she was incontinent and catheterized. Therefore, the very lowest categorization should be assigned to this error: Tier 1, Sanction Level 1.

For a Tier 2, Sanction Level 1 violation, the Disciplinary Matrix recommends a fine, and/or a warning or reprimand with stipulations that *may* include requirements such as remedial education, supervised practice, limitations on specific nursing activities, and/or periodic Board review. For a Tier 1, Sanction Level 1 violation, the sanctions are remedial education and/or a fine of $250.

The ALJ agrees that the sanction sought by Staff—a warning with probationary stipulations—is an appropriate sanction in this case. Ms. Benbow recommended remedial education and indirect supervision for one year. However, given the mitigating circumstances present in this case (especially that the facts occurred on a single day over five years ago in an otherwise unblemished career), the ALJ recommends that the probationary stipulations consist entirely of remedial education.

Accordingly, the ALJ recommends that Ms. Williams be (1) warned, and (2) ordered to take courses in the following: critical thinking, documentation, assessment, and nursing

jurisprudence and ethics.[33] If the Board determines that an additional sanction is appropriate, the ALJ recommends a fine of $250.

IV. FINDINGS OF FACT

1. Cynthia V. Williams has been licensed as a registered nurse (RN) in Texas since 2005.

2. Ms. Williams worked the 7:00 p.m.-to-7:00 a.m. night shift, on July 30, 2011, at St. Luke's Hospital at The Village (St. Luke's) in Houston, Texas.

3. During that shift, Ms. Williams was assigned to care for a patient (Patient) in the intensive care unit (ICU).

4. Patient was hospitalized for diabetic ketoacidosis (DKA).

5. Patient's chart includes standing orders titled, "DKA in Adults Physician Orders." These standing orders provided for the administration of medications should a patient's lab values for potassium or phosphorous fall below identified levels. For a phosphate blood level at certain low values, potassium phosphate was to be administered in specific amounts. For a potassium blood level at certain low values, potassium chloride was to be administered in specific amounts.

6. Patient's lab values on the afternoon of July 30, 2011, (phosphorus 1.9 milligrams per deciliter and potassium 3.8 milliequivalent per liter) met the criteria under the standing orders.

7. A handwritten physician's order in Patient's chart from 18:45 on July 30, 2011, reflected that both potassium chloride and potassium phosphate were to be administered due to the lab values.

8. Potassium chloride and potassium phosphate were not administered to Patient during the day shift preceding Respondent's night shift.

9. Ms. Williams properly administered the potassium chloride.

10. Ms. Williams failed to administer the ordered potassium phosphate.

11. Failure to administer the potassium phosphate put Patient at risk of organ damage.

12. No actual harm to Patient was shown as a result of the failure to administer the potassium phosphate.

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[33] The Board's rules require that all disciplinary orders include a requirement to complete courses in nursing jurisprudence and ethics. 22 Tex. Admin. Code § 213.33(f).

13. Ms. Williams inadvertently and incorrectly charted that Patient was incontinent and catheterized.

14. The charting error caused no harm or risk of harm.

15. Ms. Williams has no other disciplinary history and has been an ICU nurse for 10 years.

16. There is no evidence of a lack of truthfulness or trustworthiness on the part of Ms. Williams.

17. On September 9, 2016, the staff (Staff) of the Texas Board of Nursing (Board) sent its Notice of Hearing and Formal Charges to Respondent.

18. The Notice of Hearing and Formal Charges contained: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and rules involved; and (4) a short, plain statement of the factual matters asserted.

19. The hearing convened on December 13, 2016, before Administrative Law Judge Shannon Kilgore in the hearings facility of the State Office of Administrative Hearings (SOAH) in Austin, Texas. Staff was represented by Kyle Hensley, Assistant General Counsel. Respondent represented herself. The record closed the same day.

V. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code ch. 301, subch. D.

2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Ms. Williams received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

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

5. Ms. Williams is subject to discipline because she failed to administer an ordered medication. Tex. Occ. Code § 301.452(b)(10), (13); 22 Tex. Admin. Code §§ 217.11(1)(C), (M), .12(1)(A), (4).

6. Ms. Williams is also subject to discipline because she made a charting error. Tex. Occ. Code § 301.452(b)(10), (13); 22 Tex. Admin. Code §§ 217.11(1)(D), .12(1)(A), (6)(H).

7. The Board may impose a disciplinary sanction, which can range from the issuance of a written warning to revocation of a nurse's license, and may include probationary stipulations. Tex. Occ. Code § 301.453(a); 22 Tex. Admin. Code § 213.33(e).

8. To determine the appropriate disciplinary sanction to be imposed, the Board must consider the factors set forth in the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(a)-(c).

VI. RECOMMENDATION

The ALJ recommends that Ms. Williams be (1) warned, and (2) ordered to take courses in the following: critical thinking, documentation, assessment, and nursing jurisprudence and ethics. If the Board determines that an additional sanction is appropriate, the ALJ recommends a fine of $250.

SIGNED January 24, 2017.

SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS