DOCKET NUMBER 507-14-2965

IN THE MATTER OF PERMANENT CERTIFICATE NUMBERS 732636 & 194992, ISSUED TO KERRY J. ZACHARIAS	**§ § § § §**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: KERRY J. ZACHARIAS
c/o JOHNATHAN WU, ATTORNEY
3355 BEE CAVE RD., STE 307
AUSTIN, TX 78746

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 22-23, 2015, 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 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 agrees with the ALJ's recommendation that a Warning with

[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*

Stipulations is the most appropriate sanction in this case[2].

The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 5 through 31 and Conclusions of Law Numbers 7 through 11 raises concerns about the Respondent's ability to safely practice nursing. The Respondent's conduct is serious in nature[3]. Although other caregivers were involved in the care of the patient, the Respondent's conduct created a serious risk of harm for the patient and may have caused actual harm to the patient[4]. This is especially true given the patient's vulnerable state[5]. The Respondent's errors are further compounded by the fact that she failed to accurately and completely document the events that occurred, including the nursing care she provided to the patient[6]. Further, the Respondent's behavior encompasses more than one violation of the Nursing Practice Act and Board rules[7]. 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[8].

The Board is cognizant, however, of the mitigation present in this case. First, the Respondent has no prior disciplinary history with the Board, has good work history prior to and after this event, and this matter appears to be an isolated event[9]. Further, since this event, the Respondent obtained her bachelor of nursing degree[10]. Additionally, system dynamics at the facility, namely that a physician was not present on the unit during the night shift, contributed to this incident[11]. And overall, this event does not appear to be

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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] See pages 21-22 and 27 of the PFD.

[3] *See* pages 19-22 of the PFD and adopted Findings of Fact Numbers 30 and 35 and Conclusion of Law Number 10.

[4] *See id.*

[5] *See* adopted Findings of Fact Numbers 5-7.

[6] *See* adopted Finding of Fact Number 31 and Conclusions of Law Numbers 7 and 9.

[7] The Respondent is subject to discipline for two violations of the Nursing Practice Act and Board rules. See pages 19-22 of the PFD and adopted Conclusions of Law Number 7 and 9.

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

[9] *See* pages 21-22 of the PFD and adopted Findings of Fact Numbers 34-36.

[10] *See* pages 21-22 of the PFD and adopted Findings of Fact Numbers 33.

[11] *See* pages 21-22 of the PFD and adopted Finding of Fact Number 32.

representative of the Respondent's nursing ability[12].

The Board has reviewed and considered the aggravating and mitigating factors in this case and agrees with the ALJ that the Respondent's conduct constitutes a second tier, sanction level I sanction for her violations of §301.452(b)(10) & (13)[13]. Based upon the aggravating and mitigating factors, the Board agrees with the ALJ that the most appropriate sanction is a Warning with Stipulations. Further, the Board agrees with the stipulations recommended by the ALJ[14]. The Board finds that the remedial education courses required by the Order are reasonably directed to the violations committed by the Respondent and are designed to prevent future violation of a similar nature. The Board further agrees with the ALJ that incident reporting is necessary for the duration of the Order. This is a slight deviation from the stipulations that are usually associated with a Warning with Stipulations[15]. However, based upon the mitigation shown in this case, particularly the lengthy period of time in which the Respondent practiced prior, and subsequent to, this incident without complaint, the Board has determined that this deviation is warranted and is not likely to pose an additional risk of harm to patients or the public. Further, in addition to the employer notification requirements recommended by the ALJ, the Board finds it appropriate to require employer quarterly reporting to effectuate the other requirements of the Order. These stipulations are authorized under 22 Tex. Admin. Code §213.33(e)(3) 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,** in accordance with the terms of this Order.

TERMS OF ORDER

I. APPLICABILITY

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.

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[12] *See* pages 21-22 of the PFD and adopted Finding of Fact Number 35.

[13] *See* page 21 of the PFD and 22 Tex. Admin .Code §213.33(b), the Board's Disciplinary Matrix.

[14] *See* pages 21-22 and 27 of the PFD.

[15] See 22 Tex. Admin. Code §213.33(e)(3), which provides that reasonable probationary stipulations in a Warning with Stipulations may include practice for a specified period of at least one year under the direction of a registered nurse or vocational nurse designated by the Board.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT must 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.

III. 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.**

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.

B. **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.

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*

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse, providing direct patient care in a licensed healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Any quarterly period without continuous employment with the same employer for all three (3) months will not count towards completion of this requirement. 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 period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers**: RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Incident Reporting:** RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

D. **Nursing Performance Evaluations:** 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 and these reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month quarterly period for four (4) quarters [one (1) year] of employment as a nurse.

V. 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 22nd day of January, 2015.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-14-2965 (September 2, 2014).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

September 2, 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: Docket No. 507-14-2965; Texas Board of Nursing v. Kerry J. Zacharias

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,

Catherine C. Egan
Administrative Law Judge

CCE/mm
Enclosures

xc: Kerry J. Zacharias, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD; Certified Evidentiary Record) – **VIA INTERAGENCY**
Johnathan Wu, Rivas Goldstein, LLP, 3355 Bee Cave Rd., Ste. 307, Austin, TX 78746 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-14-2965

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
KERRY J. ZACHARIAS, Respondent	§	ADMINISTRATIVE HEARINGS

TABLE OF CONTENTS

SOAH DOCKET NO. 507-14-2965

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
KERRY J. ZACHARIAS, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to sanction Kerry J. Zacharias, a registered nurse (RN) and licensed vocational nurse, based on allegations that she violated the Texas Nursing Practice Act[1] and the Board rules.[2] Based on the evidence and the law, the Administrative Law Judge (ALJ) recommends that the Board enter an order issuing to Ms. Zacharias a warning with stipulations that require her to: (1) attend a course on nursing jurisprudence and ethics, and a course on nursing documentation; (2) continue working in Texas for one year as a nurse in a structured environment for at least 64 hours per month; (3) incident report to the Board for one year if she commits any other breaches of nursing standards; and (4) notify her current employer and future employers about the Board Order.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

ALJ Catherine C. Egan convened the hearing on June 19, 2014, in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Assistant General Counsel Kyle Hensley represented Staff and Attorney John Wu represented Ms. Zacharias. The record remained open for the parties to submit a legible, typewritten copy of Ms. Zacharias's October 20, 2011 statement. Mr. Hensley filed this statement on July 3, 2014, and the record closed.[3]

Matters concerning notice and jurisdiction were not contested, and are set out in the Findings of Fact and Conclusions of Law.

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[1] Tex. Occ. Code ch. 301.

[2] 22 Tex. Admin. Code ch. 217.

[3] Ms. Zacharias's typewritten statement was admitted as State Ex. 11A.

II. DISCUSSION

A. Staff's Allegations

Staff alleges that on September 8, 2011, while working as a charge nurse with Scott & White Critical Care Hospital (CCH), in Temple, Texas, Ms. Zacharias failed to adequately assess a patient and then failed to timely notify the patient's physician that the patient was experiencing a decline in oxygenation, respiratory status, and blood pressure, and had labored to agonal breathing.[4] According to Staff, Ms. Zacharias's conduct deprived this patient of an early assessment of his respiratory problems and intervention by his physician and may have contributed to the patient's death.

In addition, Staff alleges that Ms. Zacharias failed to document in the medical record her assessment of the patient and her communications with the patient's physician. This conduct, Staff asserts, resulted in an incomplete medical record and deprived other caregivers of vital information upon which to base further nursing care and interventions.

B. Applicable Law

Staff maintains that Ms. Zacharias is subject to disciplinary action because the alleged conduct constituted unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public.[5] Board Rule 217.12 sets forth specific examples of such unprofessional and dishonorable conduct, including the following:

- 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;[6]

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[4] For purposes of protecting the identity of the patient involved in the events giving rise to this case, this Proposal for Decision uses "Patient" in place of his name.

[5] Tex. Occ. Code § 301.452(b)(10).

[6] 22 Tex. Admin. Code § 217.12(1)(A).

- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[7]
- Improper management of client records;[8]
- Failing to supervise the performance of tasks by any individual working pursuant to the nurse's delegation or assignment;[9] and
- Careless or repetitive conduct that may endanger a client's life, health, or safety.[10]

Additionally, Staff asserts that Ms. Zacharias is subject to disciplinary sanction because her alleged conduct constituted a 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, exposed a patient unnecessarily to risk of harm.[11] Board Rule 217.11 identifies the standards of nursing practice for an RN, including the following cited to 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;[12]
- Implement measures to promote a safe environment for clients and others;[13]
- Accurately and completely report and document;[14]
- Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;[15]
- Supervise nursing care provided by others for whom the nurse is professionally responsible; and[16]

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

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

[9] 22 Tex. Admin. Code § 271.12(1)(F).

[10] 22 Tex. Admin. Code § 217.12(4).

[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)(B).

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

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

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

- Utilize a systematic approach to provide individualized, goal-directed, nursing care by: (i) performing comprehensive nursing assessments regarding the health status of the client; (ii) making nursing diagnoses that serve as the basis for the strategy of care; (iii) developing a plan of care based on the assessment and nursing diagnosis; (iv) implementing the nursing care, and (v) evaluating the client's response to nursing interventions.[17]

If the Board determines that a licensee has committed a sanctionable act or omission under one of the above standards, the Board shall take one or more of the following actions: issue a written warning; administer a public reprimand; limit or restrict the person's license; suspend or revoke the license; or assess a fine. Board Rule 213.33, including the Board's Disciplinary Matrix, provides guidance in determining the appropriate sanction for a violation.[18]

C. Evidence

Staff offered 13 exhibits, all of which were admitted, and called witnesses: Briana Green, RN and Staff's expert, Melinda Hester, RN, DNP.[19] Ms. Zacharias testified on her own behalf.

1. Background

Ms. Zacharias received her LVN license in Texas on September 21, 2004, and her license as an RN on August 10, 2006.[20] Both her LVN certificate and RN license are currently in effect.[21] Since the incident involved in this contested case, Ms. Zacharias obtained a bachelor degree in nursing (BSN).

On August 7, 2011, a 50-year-old quadriplegic (Patient) was admitted to Scott & White Hospital in septic shock from a urinary tract infection. While in the Intensive Care Unit (ICU),

[17] 22 Tex. Admin. Code § 217.11(3)(A).

[18] 22 Tex. Admin. Code § 213.33.

[19] State Ex. 12.

[20] State Ex. 1.

[21] State Ex. 1.

Patient developed respiratory complications, underwent a tracheotomy, and received ventilator management.[22] Because Patient experienced multiple episodes of mucus plugging, he had a bronchoscopy and underwent thorough suctioning. On September 6, 2011, Patient's tracheostomy tube was removed,[23] and on September 7, 2011, he was transferred to CCH for continued nursing care and rehabilitation.[24]

Patient exhibited positive signs of recovery on September 7, 2011, and during the day shift (7 a.m. to 7 p.m.) on September 8, 2011. However, during the night shift (7:00 p.m. to 7:00 a.m.), Patient's oxygen saturation levels declined and he ultimately died at 0102 (1:02 a.m.) that night.[25] Ms. Zacharias was the charge nurse on duty during the night shift, and she assigned the direct care of Patient to Christopher Norcross, RN.

2. Medical Records

The first day that Patient was in CCH, September 7, 2011, he complained of pain. As a result, his physician, Douglas Anderson, M.D., ordered Patient be given 20 mg of methadone by mouth twice a day.[26] Patient received his second dose of methadone at 2130 (9:30 p.m.). When the nurse went to administer the second dose of methadone, Patient told the nurse that he did not need it because he was no longer hurting.[27] At midnight, Patient complained that he was unable to wake up and felt weak. The charge nurse notified his physician, Dr. Douglas Anderson, and the dosage was reduced to 10 mg the next day.[28]

Around 8:15 p.m. on September 8, 2011, Patient complained to Mr. Norcross that something was in his throat that he could not clear. Mr. Norcross also documented that Patient's

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[22] State Ex. 5 at 109.

[23] State Ex. 5 at 112.

[24] State Ex. 5 at 109.

[25] Because the medical record refers to military time, the ALJ has referenced both.

[26] State Ex. 5 at 3.

[27] State Ex. 5 at 76.

[28] State Ex. 5 at 4, 118.

cough was weak, and his oxygen saturation level had dropped into the 80s, a low level.[29] The CCH respiratory therapist gave Patient a breathing treatment. Despite the treatment, Patient's oxygen levels remained in the 80s. At 2100 (9:00 p.m.), Mr. Norcross administered to Patient his nighttime medications.[30] By 2210 (10:10 p.m.), Mr. Norcross noted that Patient's breathing had become labored.[31] At 2300 (11:00 p.m.), Mr. Norcross noted that Patient's breathing had deteriorated from "labored to agonal" with oxygen saturations levels in the 40s.[32]

Thirty minutes later, Patient was placed on a bilevel positive airway pressure machine (BiPAP). At that point, Mr. Norcross documented that Patient's oxygen saturation levels were in the mid to lower 80s. Although Patient's oxygen levels remained in the lower 80s, shortly after midnight (0014), Patient had no heart rate or blood pressure, and a large, dark-maroon emesis was aspirated. Dr. Anderson's progress notes indicate that he was called about Patient at 0010 (12:10 a.m.). Dr. Anderson arrived at CCH shortly thereafter and at 0020 (12:20 a.m.) "coded" Patient and intubated him. Dr. Anderson also reported in his progress notes that when he intubated Patient, he found "copious amounts of gastric contents" in Patient's lungs.[33] Patient was pronounced dead at 0102 (1:02 a.m.) on September 9, 2011.[34]

Absent from Patient's medical records are any entries by Ms. Zacharias. Although she said that Mr. Norcross's nursing notes for that night were inaccurate, she did not correct Patient's medical record or make any entries indicating the entries with which she took issue.

3. CCH's Relevant Policies and Procedures

On September 8, 2011, CCH had a written policy to address a change in a patient's condition.[35] This policy required the nursing staff to contact the on-call physician and activate a

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[29] State Ex. 5 at 86. The parties agreed that normal oxygen saturations levels are in the mid-90s to 100 percent.

[30] State Ex. 5 at 86.

[31] State Ex. 5 at 86.

[32] State Ex. 5 at 87.

[33] State Ex. 5 at 122.

[34] State Ex. 5 at 87.

[35] State Ex. 7 at 1.

"Dr. Rapid" in response to an acute change in a patient's oxygen saturation levels below 90%, and any time a nurse became "worried" about a patient. In addition, CCH had a policy regarding documentation that required the nurse providing nursing care to a patient to document the care delivered.[36]

4. Testimony of Brianna Green, RN

Ms. Green has been licensed as an RN in Texas for three years. She graduated from Temple College and went to work at CCH in 2011. Ms. Green completed CCH's orientation program shortly before September 8, 2011, and was assigned to work on the night shift. She was working on the night shift the night Patient died. Ms. Zacharias was the charge nurse on duty.

According to Ms. Green, CCH is a long-term, acute-care hospital that frequently treated ventilator patients. These patients were being "weaned off" the ventilator, Ms. Green testified, and required monitoring to ensure that mucus plugs did not block the patients' airways, to maintain the proper carbon dioxide levels by measuring the patients' arterial gas blood level, and to verify that the patients' oxygen saturation levels were between 95 to 100%.[37] The CCH charge nurses, she recalled, were responsible for everything on the floor, including ensuring that the nursing staff properly cared for patients. CCH did not have a doctor on site during the overnight shift.

To monitor a patient's oxygen saturation levels, she explained, nurses relied on the continuous pulse oximeter at the nurse's station (located in the middle of the floor), as well as the patient's bedside pulse oximeter. The pulse oximeter alarm typically sounded if a patient's oxygen saturation dropped too low. Oxygen saturation levels in the 80s, Ms. Green said, would raise concerns and warrant notifying the respiratory therapist, the charge nurse, and the patient's physician. However, she clarified that before calling anyone, she would assess the patient to make sure the pulse oximeter was properly functioning because the pulse oximeter alarm went off if the patient had moved into certain positions or the oximeter finger clip had come off the

[36] State Ex. 7 at 2.

[37] Oxygen levels were measured by a pulse oximeter that was clipped onto the end of a patient's finger.

patient's finger. She agreed that if the charge nurse is busy caring for another patient, and the patient's oxygen saturation levels are low, the attending nurse must call the physician and not wait for the charge nurse to do so. Ms. Green also agreed that the nurse assigned to care for a patient has the primary responsibility to contact the patient's physician and document the call in the patient's chart.

Around 9:00 p.m. on September 8, 2011, Ms. Green testified that she noticed that Patient's oximeter alarms were sounding. At that time, Ms. Zacharias told her that she was concerned that Patient's oxygen saturation levels were in the upper 80s. According to Ms. Green, she asked Ms. Zacharias if she needed help with Patient, but Ms. Zacharias told her that she and Mr. Norcross had it handled. Later that night, Ms. Green saw the respiratory therapist, Mr. Norcross, and Ms. Zacharias transferring Patient to a room closer to the nurses' station and helped them move Patient. Ms. Green said that she also helped with the chest compressions when the Patient coded.

Ms. Green testified that charting her assessment of a patient's condition and vitals is extremely important, because others rely on this information in caring for a patient. She also agreed that methadone decreases respiratory drive because it is a central nervous system depressant.

Ms. Green acknowledged that she does not know when Patient's doctor was notified, or what intervention or treatment Patient received that night. She pointed out that she was focused on her own patients and was not in Patient's room.

5. Ms. Zacharias's Testimony

Ms. Zacharias testified that in 2009, she became a full-time employee of CCH and worked there approximately 2 years. During this time, Ms. Zacharias occasionally worked at another hospital covering up to two shifts a month.

Ms. Zacharias echoed Ms. Green's testimony that CCH cared for critical patients who were transferred from the ICU, including patients needing rehabilitation after being taken off a ventilator. As a charge nurse, she testified, CCH required her to assign the attending nurses to the care of specific patients, to assist attending nurses with patient care, to oversee patient care plans and charts, and to serve as a liaison on patient care. The charge nurse, she said, was the "go-to" person.

On September 8, 2011, Ms. Zacharias was overseeing three nurses—Ms. Green, Amanda White, and Mr. Norcross. She assigned the care of three patients to each nurse and assigned herself the two patients requiring total care. Additionally, two registered respiratory therapists were on duty that night. Respiratory therapist Elma Rivers, a seasoned veteran, was assigned to Ms. Zacharias's floor because of her higher level of training. If a patient's oxygen saturation level dropped below 90%, an alarm sounded because, she explained, a low oxygen saturation level could indicate that the patient is septic, hypothermic, breathing too rapidly, or breathing too little, among other things.

Ms. Zacharias noted that Patient was completely decanulated (removal of a tracheostomy cannula, the tube) before he was transferred to CCH on September 7, 2011, and was breathing on his own. A band-aid covered the tracheostomy opening. That night, Ms. Zacharias recalled, she reviewed the care plan in the chart for each patient with the day-shift charge nurse and was informed that Patient was breathing well. Although Patient got cold easily, he was covered with a "bear hugger" that blew warm air to keep him warm. Although she did not know all the medications that Patient was taking, Ms. Zacharias said she remembered thinking it unusual for a quadriplegic to be prescribed methadone because it is a pain medication and can slow down the patient's respiration.

Ms. Zacharias testified that she believed Patient would be an easy patient for Mr. Norcross to manage because the charge nurse said Patient was in no distress. She explained that she did not trust Mr. Norcross's nursing ability, and had previously reported her concerns about Mr. Norcross's deficits to management, but he was still working at CCH that night.

According to Ms. Zacharias, she did not hear Patient's oximeter alarm on September 8, 2011, until 2200 (10:00 p.m.). Ms. Zacharias told the respiratory therapist, Ms. Rivers, to check on Patient. Ms. Rivers reported to Ms. Zacharias that the alarm sounded because the probe on his finger was malfunctioning. Once fixed, Ms. Zacharias said that she saw on the nurse's station oximeter that Patient's oxygen level returned to 97%. Thirty minutes later, the oximeter alarm sounded again after Patient's oxygen level dropped into the 80s. Ms. Rivers returned to Patient's room and later reported to Ms. Zacharias that Patient had fallen asleep and was not breathing deeply enough. Ms. Rivers put a nasal cannula on Patient to administer 2 liters of oxygen and, according to Ms. Zacharias, Patient's oxygen saturation level returned to 98%. Around 2300 (11:00 p.m.), Ms. Zacharias heard Patient's oximeter alarm again. This time Ms. Zacharias went into Patient's room with Ms. Rivers, but she emphasized Mr. Norcross just sat outside Patient's room.

Ms. Zacharias recalled that Ms. Rivers suctioned Patient's airway just in case mucous was blocking his breathing, but found none. Ms. Zacharias did not listen to Patient's lungs, but she said that Ms. Rivers did, and then told her that his lungs were clear. Because Patient was slouched in a way that restricted his airways, she and Ms. Rivers laid Patient flat on his bed, moved him up in the bed, and then returned him to a sitting position to open his airways. While Patient was lying flat, his oxygen saturation level dropped to 69%. In response, Ms. Rivers increased the oxygen to 3 liters. Patient's oxygen saturations levels only returned to the 80s. Ms. Zacharias testified that she did not notify Dr. Anderson about the drop in Patient's oxygen saturation level because Ms. Rivers told Ms. Zacharias that she wanted to draw Patient's arterial blood to measure his arterial gas levels before they called Dr. Anderson. Ms. Zacharias also said that she told Mr. Norcross to page Dr. Anderson around this time and Mr. Norcross told her that he did. At this point, Ms. Zacharias said that she left to check on her patients.

When Ms. Zacharias returned to Patient's room 10 to 15 minutes later, both respiratory therapists were drawing Patient's arterial blood. Ms. Rivers then placed Patient on a BiPAP machine to force oxygen into his lungs, and Ms. Zacharias instructed Mr. Norcross to page Dr. Anderson again because the doctor had not answered the first page. This was around 2330 (11:30 p.m.). Dr. Anderson called shortly after the second page, and Ms. Zacharias advised him that Patient's oxygen saturation level was in the 80s and that they were putting him on the BiPAP machine. Dr. Anderson ordered that Patient be given Narcan, a drug to counteract the effects of a narcotic (the methadone). Ms. Zacharias told Dr. Anderson that she did not think Patient needed Narcan because he was alert and had no altered mental status. Dr. Anderson still ordered that Narcan be administered to Patient.

Mr. Norcross gave Patient the medication, and shortly thereafter, Patient became sleepy and difficult to arouse, according to Ms. Zacharias. She told Mr. Norcross to keep Patient awake even if he had to do a sternum rub because the pain would keep him aroused.[38] The blood gas results returned and it was evident that Patient was declining so Ms. Zacharias called Dr. Anderson again. Ms. Rivers recommended that they move Patient closer to the nurses' station and into the high observation room because Patient was likely to be re-intubated, and Ms. Zacharias said she agreed. During the move, Ms. Zacharias recalled that Patient's heart rate dropped and he vomited. To prevent him from aspirating, they rolled Patient on his side. Dr. Anderson arrived about 7 minutes later, and issued a "Code Blue" because Patient's heart rate dropped to the low 30s. Efforts to revive Patient failed and he died at 0102 (1:02 a.m.).

As for the documentation, Ms. Zacharias acknowledged that she did not document what she did that night in Patient's medical records although she had a duty to do so. She reasoned that because Ms. Rivers documented in Patient's medical record what they were doing, albeit not in the nursing notes, this excused her from documenting her care in the medical record. She also argued that because the attending nurse usually documented what happened with their patients, she thought Mr. Norcross would document what she was doing for his patient, as she was busy talking to Dr. Anderson and trying to help Ms. Rivers with Patient.

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[38] Ms. Zacharias explained that a sternum rub hurts the patient so that they stay awake, but the evidence is unclear whether Patient, a quadriplegic, could feel his sternum.

The following shift that Ms. Zacharias worked, she said that she talked to Mr. Norcross about the inaccuracies in his charting. Mr. Norcross told her that he was in a rush and got confused on the times. Ms. Zacharias testified that she asked Mr. Norcross to correct his charting errors, but was unaware that he had not done so until CCH terminated her employment on October 17, 2011.[39]

Ms. Zacharias also insisted that Dr. Anderson was paged within 30 minutes of Patient's change in condition. She emphasized that it is essential to first treat the patient and then call the doctor. Moreover, she stated, Patient's oxygen saturation level did not stay in the 60s, but with adjustments, his oxygen saturation levels returned to the 80s.

Ms. Zacharias acknowledged that she should have documented what she did for Patient, but adamantly denied that she caused a delay in Patient's treatment by not contacting Dr. Anderson earlier. She insisted that she contacted Dr. Anderson in a timely manner because she had him paged within 30 minutes of learning that Patient's oxygen saturation levels had dropped. However, Ms. Zacharias conceded that if Mr. Norcross' entry at 2010 (8:10 p.m.) was accurate and Patient's oxygen saturation levels had dropped into the 80s, waiting until 2330 (11:30 p.m.) to contact Dr. Anderson would have created a delay in care.

After her termination, on October 20, 2011, Ms. Zacharias wrote a statement about what happened that night. Although she did not have access to any medical records at that time, she said that she relied on her memory and Ms. Rivers' recollection. Ms. Zacharias' testimony largely follows the details in her written statement.[40]

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[39] State Ex. 11.

[40] State Ex. 11A.

6. Dr. Hester's Testimony

Dr. Hester, the Board's Lead Practice Consultant, explained that the term "standard of care" refers to a nurse's duty to provide safe nursing services to the patient. Being a charge nurse, she clarified, does not excuse a nurse from providing care to the patient or from documenting the assessment of and care given to a patient.

After reviewing the complaint, the exhibits, and listening to the testimony presented at the hearing, Dr. Hester opined that Ms. Zacharias committed a number of violations. Specifically, Dr. Hester found that Ms. Zacharias failed to care adequately for Patient and failed to comply with the minimum standards of acceptable nursing practices that exposed Patient unnecessarily to risk of harm in violation of Texas Occupations Code § 301.452 (b)(13), when she failed to do the following:

- Comply with CCH's policy on when to contact the on-call physician by failing to timely report to Dr. Anderson Patient's declining oxygen saturation levels;[41]
- Implement measures to promote a safe environment for Patient;[42]
- Perform and document her assessment and treatment of Patient; [43]
- Intervene to stabilize Patient's condition and prevent complications;[44]
- Properly assign Patient's care to Mr. Norcross and adequately supervise Mr. Norcross's care of Patient;[45] and
- Perform a comprehensive nursing assessment around 2100 (9:00 p.m.) regarding Patient's health status, develop and implement a plan of care for Patient, and evaluate Patient's responses to the care.[46]

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[41] 22 Tex. Admin. Code § 217.11(1)(A).

[42] 22 Tex. Admin. Code § 217.11(1)(B).

[43] 22 Tex. Admin. Code § 217.11(1)(D).

[44] 22 Tex. Admin. Code § 217.11(1)(M).

[45] 22 Tex. Admin. Code § 217.11(1)(U).

[46] 22 Tex. Admin. Code § 217.11(3)(A).

Turning to the issue of unprofessional conduct, Dr. Hester pointed out that by failing to practice nursing in compliance with minimum nursing standards set out in Board Rule 217.11 and in compliance with CCH's policies on the night of September 8, 2011, Ms. Zacharias engaged in unprofessional conduct.[47] In addition, Dr. Hester concluded that Ms. Zacharias engaged in unsafe practices constituting unprofessional conduct that could endanger a patient's health by failing to document her care of Patient and thereby improperly managing Patient's medical records. She also found that Ms. Zacharias failed to supervise Mr. Norcross in his care of Patient despite questioning his nursing abilities.[48]

According to Dr. Hester, when Ms. Zacharias first suspected that Patient had a problem with his oxygen saturation levels, she needed to do her own assessment of his condition. Based on the medical records and Ms. Green's testimony, Dr. Hester believes that Ms. Zacharias became aware of Patient's low oxygen saturation levels around 9:00 p.m. Dr. Hester pointed out that even Ms. Green, a new nurse, appreciated that something was wrong with Patient and offered to help shortly after the night shift began.

In an acute-care situation, Dr. Hester stated that a nurse has a heightened duty to be vigilant about the patients and may not rely solely on monitors, including an oximeter. Further, she stated, a nurse may not rely solely on a registered respiratory therapist to evaluate and assess a patient's condition, although a nurse should consider the respiratory therapist's data. It was even more important for Ms. Zacharias to perform her own assessment of Patient, Dr. Hester opined, because Ms. Zacharias said she did not trust Mr. Norcross's nursing abilities and had even reported his poor performance to the administration. As the charge nurse, Ms. Zacharias was obligated to assign a nurse to care for Patient who was qualified, capable, and had the skill and knowledge to care for him and to supervise the nurse's performance. Ms. Zacharias's distrust in Mr. Norcross's nursing abilities warranted scrutiny of the patients assigned to his care to ensure that the patients received proper care.

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[47] 22 Tex. Admin. Code § 217.12(1)(A), (B).

[48] 22 Tex. Admin. Code § 217.12(1)(C), (F), and (4).

Although Dr. Hester appreciated that Ms. Zacharias assigned herself two total care patients that night, when Patient's oxygenation saturation levels dropped into the 80s, Dr. Hester said that Ms. Zacharias should have overseen and coordinated his care. In Dr. Hester's opinion, waiting until 2300 (11:00 p.m.), the third time the oximeter alarm sounded, to intervene was below the standard of care. In addition, when Ms. Zacharias did go to Patient's room, Dr. Hester maintains that she should have listened to Patient's lungs and charted all of Patient's vital signs to properly assess Patient's condition irrespective of what the respiratory therapist reported. If Patient's other vital signs were declining, Dr. Hester explained, Ms. Zacharias would have known that there was a bigger problem than a "false reading" on the oximeter.

Turning to the issue of when a physician should have been called, Dr. Hester testified that a prudent nurse would have called Dr. Anderson by 2100 (9:00 p.m.) or soon after Ms. Zacharias told Ms. Green that she was concerned about Patient's condition. When Patient's oxygen saturation levels dropped to 67% at 11:00 p.m., it was a "red flag" that Ms. Zacharias should have immediately reported to the doctor, according to Dr. Hester. This is true, she clarified, even if Patient's oxygen saturation level immediately returned to the low 80s. Further, Dr. Hester stated that Ms. Zacharias should have called Dr. Anderson to report that Patient's oxygen saturation levels remained in the 80s because these are low readings.

Dr. Hester also noted that the day charge nurse had documented that Patient complained that the methadone was making him feel weak. In response, the day charge nurse notified Dr. Anderson and secured a new order for 10 mg rather than 20 mg of methadone. As a quadriplegic, Dr. Hester explained, Patient had little lung strength. Moreover, Patient had recently been taken off a ventilator, had recently been given methadone, and had complained that methadone made him feel weak. Dr. Hester asserted that, in view of these factors, Ms. Zacharias should have been hyper-vigilant when Patient began experiencing respiratory problems.

According to Dr. Hester, Ms. Zacharias depended too heavily on the respiratory therapist to determine when to call Dr. Anderson and what course of treatment to follow. Ms. Zacharias appeared to defer to the respiratory therapist when the respiratory therapist wanted to secure Patient's arterial blood gases before paging the physician. Dr. Hester emphasized that

Ms. Zacharias, as the charge nurse, should have overridden the respiratory therapist's recommendation, and promptly notified Dr. Anderson of Patient's declining condition.

As for the lack of documentation by Ms. Zacharias, Ms. Hester highlighted how difficult it is to know what Ms. Zacharias did or when she became concerned about Patient. A charge nurse who provides hands-on care to a patient, Dr. Hester testified, must document her care in the medical record. Specifically, Dr. Hester maintains that Ms. Zacharias should have documented Patient's status and condition, Patient's signs and symptoms, her interventions, her assessment, her evaluations, any orders received, and any contact that she had with the doctor, the respiratory therapist or others members of the health care team. Ms. Hester dismissed Ms. Zacharias's October 20, 2011 written statement as unreliable. Although a nurse may make late entries in a medical record to correct information in a patient's chart so that the record accurately and completely documents patient care, Dr. Hester stressed that Ms. Zacharias failed to do so. According to Dr. Hester, the documentation needed to be done that night or the following day, not a month later, and needed to be in Patient's medical records. Ms. Zacharias's October statement was not part of Patient's medical record.

Dr. Hester concluded that Ms. Zacharias's nursing performance that night was below the minimum standards of acceptable nursing practices and constituted unprofessional conduct that injured Patient by delaying care when such delay could have contributed to his death.[49] She stressed that Ms. Zacharias engaged in unsafe practices when she failed to follow CCH's policy regarding when to notify a patient's doctor; failed to document what she saw and did for Patient; failed to properly supervise Mr. Norcross's performance; and was careless in her assessment of Patient's condition, instead relying on a respiratory therapist.[50]

In assessing the appropriate sanction to impose for violations of Section 301.452(b)(13) for Ms. Zacharias's failure to care adequately for Patient or to conform to the nursing standards, Dr. Hester relied on 22 Texas Administrative Code § 213.33 and the Disciplinary Matrix. Although Mr. Norcross was ultimately responsible for Patient's nursing care, Dr. Hester

[49] Tex. Occ. Code § 301.452(b)(10).

[50] 22 Tex. Admin. Code §§ 217.12(1)(A)-(C), (F), (4).

reiterated that Ms. Zacharias also had responsibility to Patient as the charge nurse. For violations of Texas Occupations Code § 301.452(b)(13), Dr. Hester testified that she considered Ms. Zacharias's conduct a second tier offense because it was below the standard of care and contributed to patient harm, and opined that it warranted a warning with stipulations, a sanction level I.

Dr. Hester reviewed the aggregating and mitigating factors listed in the Disciplinary Matrix and acknowledged that this was an isolated incident. But, she also pointed out that this incident caused actual harm to Patient, a particularly vulnerable patient. Dr. Hester also noted that Ms. Zacharias has no other disciplinary complaints or Board orders; obtained her bachelor degree in nursing (BSN), a significant accomplishment; and has worked in ICU with higher-acuity patients since 2008, without any complaints. According to Dr. Hester, these facts reflect a high level of competency. According to Dr. Hester, CCH's failure to have a doctor on duty at night was a system's issue because a physician should have been on-site for patients with such a high level of acuity. CCH has since required that a physician be on-site during the night shift.

Turning to the violations of Section 301.452(b)(10) regarding unprofessional conduct that in the Board's opinion is likely to injure a patient as set out in Board rule 217.12, Dr. Hester said that she did a similar analysis as above to determine what sanction to impose. She explained that she reviewed the aggravating and mitigating factors set out for this violation in the Disciplinary Matrix. In her opinion, this was a second tier offense, sanction level I. Again, Dr. Hester recommended that Ms. Zacharias receive a warning with stipulations for this violation for the same reasons set forth above.

The stipulations, Dr. Hester recommends, include requiring Ms. Zacharias to complete in person a course in nursing jurisprudence and ethics and a course in documentation. The warning would remain in effect for one year, during which time Ms. Zacharias would have to continue working in Texas as a nurse in a structured environment for at least 64 hours a month. In addition, she recommends that Ms. Zacharias be required to do incident reporting to the Board if she commits any other breaches of nursing standards, for example if Ms. Zacharias is written up by a hospital, it must be reported to the Board. Finally, Ms. Zacharias must notify her current employer and future employers about the Board Order.

D. ALJ's Analysis and Recommendation

1. Sanctionable Conduct

Section 301.452(b)(13) Failure to Conform to Nursing Standards

The preponderance of the evidence strongly indicates that Ms. Zacharias knew that Patient was having respiratory issues around 2100 (9:00 p.m.) on September 8, 2011. Although Ms. Zacharias contends that she did not know of Patient's declining condition until 2300 (11:00 p.m.), the medical record and Ms. Green's testimony indicate otherwise. Ms. Green persuasively testified that Ms. Zacharias was aware Patient's oximeter alarm had sounded and was concerned about his condition at 2100 (9:00 p.m.), and the medical records indicate that Patient's oxygen saturation level began dropping at 2015 (8:15 p.m.).

Once Ms. Zacharias knew that Patient's oxygen saturation levels had dropped significantly, she had a duty to implement measures to promote a safe environment for Patient. As the charge nurse, Ms. Zacharias had a duty to institute appropriate nursing interventions required to stabilize Patient's condition and prevent complications by performing a comprehensive nursing assessment of Patient's health status, making nursing diagnoses and developing and implementing a plan of care, and then evaluating Patient's response to these nursing interventions. She failed to do so.

In addition, she was required to know the rules affecting her nursing practice including the rules governing the nursing practices where she worked—CCH's Policies and Procedures. On September 8, 2011, CCH had a policy requiring the nursing staff to contact the on-call physician, in this case Dr. Anderson, when a change occurred in a patient's condition, including an acute change in oxygen saturation less than 90%. When Ms. Zacharias learned that Patient's oxygen saturation level dropped into the 80s around 2100 (9:00 p.m.), Ms. Zacharias had a duty to promptly report this change in Patient's condition to Dr. Anderson. She failed to do so.

CCH's policy regarding documentation required that the nurse delivering care to a patient document that care. Ms. Zacharias failed to accurately and completely report and document the

care she provided to Patient that night. Ms. Zacharias's observations, assessments, and interventions from that night are conspicuously absent from Patient's medical records. By relying on Mr. Norcross to document her care even though she claimed he remained outside Patient's room most of the time, and on the respiratory therapist to chart her assessment and treatment, Ms. Zacharias not only violated CCH's policy regarding documentation, she prevented other caregivers that night from having pertinent information about Patient's condition. If, as Ms. Zacharias testified, she did not have time that night to document the care she provided Patient, she should have made a late entry into Patient's medical record the following day or during her next shift. Creating a written statement more than a month after Patient died, and only after CCH terminated her employment, does not constitute proper documentation. Ms. Zacharias had a duty to document the nursing care she provided Patient, and failed to do so.

Based on this evidence, the ALJ concludes that Ms. Zacharias failed to perform nursing in conformity with the standards of minimum acceptable level of nursing practice in a manner that unnecessarily exposed a patient to risk of harm in violation of Texas Occupations Code § 301.452(b)(13). Ms. Zacharias did so by: (1) failing to timely contact Patient's physician when his oxygen saturation levels dropped into the 80s and below; (2) failing to perform a comprehensive assessment of Patient's health status at or around 2100 (9:00 p.m.); (3) failing to institute appropriate nursing interventions to stabilize Patient's condition and prevent complications; (4) failing to accurately and completely report and document the care she provided Patient; and, (5) failing to implement measures to promote a safe environment for Patient in violation of 22 Texas Administrative Code § 217.11(1)(A), (B), (D), (M), (U), and 3(A).

Section 301.452(b)(10) Unprofessional Conduct

Ms. Zacharias's conduct on September 8, 2011, also constituted unprofessional conduct as set out in Board Rule 217.12 and was likely to injure a patient. As noted above, Board Rule 217.12 clarifies the practices that constitute unprofessional conduct. Having already found that Ms. Zacharias failed to conform to the minimum standards of acceptable nursing practices listed in Board Rule 217.11 and that she failed to comply with CCH's policies regarding notification to

the on-call physician of a change in a patient's condition and documentation, she also violated Board Rule 217.12(1)(A), (B), and (4). In addition, Ms. Zacharias's failure to document what she observed and what nursing care she provided to Patient as well as her failure to note corrections in Patient' medical records to the alleged inaccuracies in Mr. Norcross's nursing notes constitutes an improper management of client records in violation of Board Rule 217.12(C). Finally, Ms. Zacharias's failure to supervise Mr. Norcross's performance in his care of Patient violated Board Rule 217.12(F).

2. Sanction

The only remaining issue to determine is the appropriate sanction to impose for each violation. This was an isolated incident in Ms. Zacharias's nursing career. As Dr. Hester testified, Ms. Zacharias' violations of Texas Occupations Code § 301.452(b)(10) and (13) are second tier offenses under the Board's Disciplinary Matrix. The first tier for a Section 301.452(b)(10) offense speaks of "isolated" failures that had "no adverse patient effect." As Ms. Hester correctly pointed out, Ms. Zacharias conduct may have contributed to Patient's demise and therefore is a second tier offense. Similarly, the second tier is applicable to Ms. Zacharias's Texas Occupations Code § 301.452(b)(13) offense. The first tier relates to substandard practices with a "low risk" of patient harm, but the second tier encompasses both actual harm and risk of harm.

After the appropriate tier is identified, the Disciplinary Matrix requires an examination of aggravating and mitigating factors in order to determine what sanction level is warranted. Ms. Hester correctly identified applicable aggravating and mitigation circumstances as including the isolated nature of the conduct; the patient's vulnerability; Ms. Zacharias nursing achievement in attaining a BSN; the lack of any other complaints or Board orders despite working in ICU since this incident; and CCH's failure to have a physician on-site during the night shift. Therefore, Ms. Zacharias's actions warrant sanctions for second tier violations of § 301.452(b)(10) and (13), at sanction level I.

A warning with stipulations, as recommended by Dr. Hester, is available under the Disciplinary Matrix for second-tier violations of § 301.452(b)(10) and (13), sanction level I. The

stipulations recommended by Dr. Hester also appear warranted. Therefore, the ALJ recommends that Ms. Zacharias receive a warning with stipulations that include requirements to: attend a course in nursing jurisprudence and ethics and a course in documentation; continue working for a year in Texas as a nurse in a structured environment for at least 64 hours a month; incident report to the Board if she commits any other breaches of nursing standards; and notify her current employer and future employers about the Board Order.

III. FINDINGS OF FACT

1. Kerry J. Zacharias is licensed as a vocational nurse and registered nurse (RN) by the Texas Board of Nursing (Board).

2. On April 2, 2014, the Board's staff (Staff) mailed its Notice of Hearing to Ms. Zacharias.

3. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

4. The hearing convened June 19, 2014, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Assistant General Counsel R. Kyle Hensley represented Staff and attorney John Wu represented Ms. Zacharias. The record closed on July 3, 2014.

5. On August 7, 2011, a 50-year-old quadriplegic (Patient) was admitted into Scott & White Hospital in septic shock from a urinary tract infection.

6. While in Scott & White Hospital's intensive care unit (ICU), Patient developed respiratory complications, underwent a tracheotomy, and was placed on a ventilator.

7. On September 6, 2011, Patient's tracheostomy tube was removed, and the following day he was transferred to Scott & White's Critical Care Hospital (CCH) for continued nursing care and rehabilitation.

8. Patient complained of pain on September 7, 2011, after being transferred from ICU to CCH. In response, his physician, Douglas Anderson, M.D., ordered Patient be given 20 mg of methadone, a central nervous system depressant that decreases respiratory drive.

9. Patient received his second dose of methadone at 2130 (9:30 p.m.) on September 7, 2011. When Patient was given this second dose, he told the nurse that he did not need it because he no longer hurt.

10. At midnight, Patient complained that he was unable to wake up and felt weak. The nursing staff reported this condition to Dr. Anderson, and in response, Dr. Anderson reduced the methadone dosage by half (10 mg).

11. On September 8, 2011, Ms. Zacharias was the assigned charge nurse at CCH during the night shift (7:00 a.m. to 7:00 p.m.). Ms. Zacharias assigned Patient to the care of Christopher Norcross, RN.

12. Ms. Zacharias did not trust Mr. Norcross' nursing abilities and had reported this to CCH's administration.

13. Around 2015 (8:15 p.m.) that night, Patient complained that something was in his throat that he could not clear. Patient's cough was weak and his oxygen saturation level had dropped into the 80s, a low level.

14. A normal oxygen saturation level is between the mid-90s and 100%.

15. Around 2100 (9:00 p.m.), Ms. Zacharias told another nurse that she was worried about Patient's oxygen saturation levels after Patient's oximeter alarm sounded indicating that his oxygen saturation level had dropped below 90%.

16. Ms. Zacharias had a duty to assess Patient's condition at that time, yet failed to do so.

17. Ms. Zacharias had a duty to notify Dr. Anderson of Patient's change of condition at that time, but instead sent a respiratory nurse into Patient's room to assess and evaluate Patient's condition.

18. Thirty minutes later, Ms. Zacharias again heard the oximeter alarm for Patient, and again she sent the respiratory therapist into Patient's room to assess Patient's condition.

19. Ms. Zacharias had a duty to perform her own assessment of Patient, and failed to do so.

20. Ms. Zacharias had a duty to notify Dr. Anderson of this change of condition, and did not.

21. At 2300 (11:00 p.m.), Ms. Zacharias heard Patient's oximeter alarm sound again and went with the respiratory therapist to Patient's room.

22. At that time, Patient's breathing had deteriorated from labored to agonal and his oxygen saturation levels had declined into the 40s.

23. Although present in the room, Ms. Zacharias did not assess and evaluate Patient's condition, but instead relied on the respiratory therapist to take Patient's vital signs and listen to Patient's lungs.

24. As the charge nurse, Ms. Zacharias had a duty to assess Patient's condition and report Patient's change in condition to Dr. Anderson. Ms. Zacharias did not do so.

25. Ms. Zacharias did not notify Dr. Anderson about Patient's respiratory decline or the significant drop in his oxygen saturation levels until shortly before midnight.

26. Dr. Anderson arrived shortly thereafter, and issued a "Code Blue" and intubated Patient. When he intubated Patient, Dr. Anderson found copious amounts of gastric content in Patient's lungs.

27. Patient was pronounced dead at 0102 (1:02 a.m.) on September 9, 2011.

28. Ms. Zacharias did not document any of her observations of Patient or any of her interventions in Patient's medical records. In fact, Ms. Zacharias made no entries into Patient's medical records on September 8, 2011, even though she could have made late entries over the following days.

29. Ms. Zacharias's conduct exposed Patient unnecessarily to the risk of harm when she failed to do the following:

- Timely notify Dr. Anderson about Patient's deteriorating respiratory condition, specifically his declining oxygen saturation levels;
- Provide a safe environment for Patient;
- Perform and document her own assessment and her interventions and care provided to Patient;
- Intervene timely to prevent complications and stabilize Patient's condition; and
- Properly assign Patient's care to Mr. Norcross, a nurse whose nursing abilities she questioned, and adequately supervise Mr. Norcross's care of Patient.

30. Ms. Zacharias's conduct deprived Patient of an early assessment and detection of the cause for the decline in his oxygen saturation level and his respiratory condition, and may have contributed to Patient's death.

31. Ms. Zacharias's failure to document in Patient's medical record her assessment of the patient, her interventions, and her communications with Dr. Anderson about Patient's respiratory complications resulted in an incomplete medical record and deprived subsequent caregivers of vital information upon which to base further nursing care and treatment.

32. System dynamics at CCH contributed to this incident, including CCH's failure to have a physician on site to address such problems during the night shift.

33. After this incident, Ms. Zacharias obtained her bachelor of nursing degree.

34. Since her termination from CCH in October 2011, Ms. Zacharias has worked in the ICU at another hospital without incident, even though this environment has a higher acuity level than the critical care unit.

35. This was an isolated incident, and while not representative of Ms. Zacharias's nursing ability, may have contributed to actual harm to Patient.

36. Ms. Zacharias has not previously been the subject of any Board Orders.

IV. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings has jurisdiction over the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Gov't Code ch. 2003; Tex. Occ. Code 301.459.

3. Proper and timely notice of the hearing was provided. Tex. Gov't Code ch. 2001.051-.053; Tex. Occ. Code § 301.455.

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

5. A nurse is subject to discipline for unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public. Tex. Occ. Code § 301.452(b)(10).

6. A nurse is subject to discipline for failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm. Tex. Occ. Code § 301.452(b)(13).

7. Ms. Zacharias violated the following minimum standards of acceptable nursing practice on September 8, 2011, by failing to:

   - Conform to the Texas Nursing Practice Act and Board rules and regulations, as well as federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing when she failed to comply with the Board rules and CCH's policies. 22 Tex. Admin. Code § 217.11(1)(A).

   - Implement measures to promote a safe environment for Patient by failing to assess Patient and timely intervene in his care and failing to timely report to the physician the drop of Patient's oxygen saturation levels into the 80s and below. 22 Tex. Admin. Code § 217.11(1)(B).

   - Accurately and completely report and document in Patient's medical records the nursing care she provided Patient on September 8, 2011. 22 Tex. Admin. Code § 217.11(1)(D).

- Institute appropriate nursing interventions that might be required to stabilize Patient's condition and/or prevent complications. 22 Tex. Admin. Code § 217.11(1)(M);

- Supervise nursing care provided by others, specifically Mr. Norcross, for whom she was professionally responsible. 22 Tex. Admin. Code § 217.11(1)(U).

- Utilize a systematic approach to provide individualized, goal-directed, nursing care by: (i) performing comprehensive nursing assessments regarding the health status of the client; (ii) making nursing diagnoses that serve as the basis for the strategy of care; (iii) developing a plan of care based on the assessment and nursing diagnosis; (iv) implementing the nursing care, and (v) evaluating the client's response to nursing interventions. 22 Tex. Admin. Code § 217.11(3)(A).

8. Ms. Zacharias' conduct is sanctionable pursuant to Texas Occupations Code § 301.452(b)(13).

9. On September 8, 2011, Ms. Zacharias engaged in the following unprofessional conduct:

- 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 in violation of 22 Texas Administrative Code § 217.12(1)(A).

- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings by failing to comply with CCH's policies in violation of 22 Texas Administrative Code § 217.12(1)(B).

- Improperly managing client records by failing to document the care she provided Patient and failing to make entries in Patient's medical record to correct any perceived inaccuracies in Mr. Norcross's nursing notes in violation of 22 Tex. Admin. Code § 217.12(1)(C).

- Careless or repetitive conduct that may endanger a client's life, health, or safety. 22 Tex. Admin. Code § 217.12(4).

10. The unprofessional conduct described above was careless and may have endangered Patient's life in violation of 22 Texas Administrative Code § 217.12(4).

11. Ms. Zacharias' conduct is sanctionable pursuant to Texas Occupations Code § 301.452(b)(10).

12. If the Board determines that a licensee has committed a sanctionable act, the Board shall take one or more of the following actions: issuance of a written warning; administration

of a public reprimand; limitation or restriction of the person's license; suspension of the license; revocation of the license; or assessment of a fine. Tex. Occ. Code § 301.453.

13. The Board's Disciplinary Matrix, 22 Tex. Admin. Code § 213.33(b), provides guidance in determining the appropriate sanction for a violation.

14. The Board's rules specify factors to be used in disciplinary matters. 22 Tex. Admin. Code § 213.33(c).

V. RECOMMENDATION

The ALJ recommends that Ms. Zacharias receive for one year a written warning with stipulations that she be required to: successfully complete an in person course in nursing jurisprudence and ethics and a course in documentation; continue working in Texas for one year as a nurse in a structured environment for at least 64 hours per month; incident report to the Board if she commits any other breaches of nursing standards; and that she notify her current employer and future employers about the Board Order.

SIGNED September 2, 2014.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

APPENDIX

§301.452(b)(10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public;		
First Tier Offense: Isolated failure to comply with Board rules regarding unprofessional conduct resulting in unsafe practice with no adverse patient effects. Isolated violation involving minor unethical conduct where no patient safety is at risk, such as negligent failure to maintain client confidentiality or failure to honestly disclose or answer questions relevant to employment or licensure.*	Sanction Level I: Remedial Education and/or a fine of $250 or more for each additional violation. Elements normally related to dishonesty, fraud or deceit are deemed to be unintentional.	Sanction Level II: Warning with Stipulations that may include remedial education; supervised practice; perform public service; limit specific nursing activities; and/or periodic Board review; and/or a fine of $500 or more for each additional violation. Additionally, if the isolated violations are associated with mishandling or misdocumenting of controlled substances (with no evidence of impairment) then stipulations may include random drug screens to be verified through urinalysis and practice limitations.
Second Tier Offense: Failure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious risk to patient or public safety. Repeated acts of unethical behavior or unethical behavior which places patient or public at risk of harm. Personal relationship that violates professional boundaries of nurse/patient relationship.	Sanction Level I: Warning or Reprimand with Stipulations which may include remedial education, supervised practice, and/or perform public service. Fine of $250 or more for each violation. If violation involves mishandling or misdocumenting of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances, then the stipulations will also include abstention from unauthorized use of drugs and alcohol, to be verified by random drug testing through urinalysis, limit specific	Sanction Level II: Denial of Licensure, Suspension, or Revocation of Licensure. Any Suspension would be enforced at a minimum until nurse pays fine, completes remedial education and presents other rehabilitative efforts as prescribed by the Board. If violation involves mishandling of controlled substances, misdemeanor crimes or criminal conduct involving alcohol, drugs or controlled substances then suspension will be enforced until individual has completed treatment and

	nursing activities, and/or periodic Board review. Board will use its rules and disciplinary sanction polices related to drug or alcohol misuse in analyzing facts. http://www.bon.state.tx.us/disciplinaryaction/dsp.html.	one year verifiable sobriety before suspension is stayed, thereafter the stipulations will also include abstention from unauthorized use of drugs and alcohol to be verified by random drug testing through urinalysis; limit specific nursing activities and/or periodic Board review. Probated suspension will be for a minimum of two (2) or three (3) years with Board monitored and supervised practice depending on applicable Board policy. Financial exploitation of a patient or public will require full restitution before nurse is eligible for unencumbered license.