BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Registered Nurse License Number 838381	§	
& Vocational Nurse License Number 186514	§	
issued to KRISTI DENISE PORTER	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of KRISTI DENISE PORTER, Registered Nurse License Number 838381 and Vocational Nurse License Number 186514, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10),(12)&(13), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on July 14, 2017.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Order.

3. Respondent's license to practice as a vocational nurse in the State of Texas is in delinquent status. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from South Plains College, Plainview, Texas, on August 15, 2002, and received an Associate Degree in Nursing from South Plains College, Levelland, Texas, on May 9, 2013. Respondent was licensed to practice vocational nursing in the State of Texas on October 31, 2002, and was licensed to practice professional nursing in the State of Texas on June 20, 2013.

5. Respondent's nursing employment history includes:

2002-2004	LVN Charge Nurse	Plainview Health Care Center Plainview, Texas
2004-2014	LVN and RN	Legend of the Plain Hale Center, Texas
March 2009-March 2017	Owner/DON	Littlefield Hospitality Littlefield, Texas
March 2017-Present	Nurse Executive	Genesis Health Care- Lubbock Hospitality House Nursing and Rehabilitation Center Lubbock, Texas

6. At the time of the initial incident, Respondent was employed as Director of Nursing/Owner of Littlefield Hospitality, Littlefield, Texas, and had been in that position for five (5) years and nine (9) months.

7. On or about December 23, 2014, through October 6, 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to timely encode, submit, and transmit patient data on Residents SS, JW, OB, JG, TB, and RR. Respondent's conduct resulted in incomplete medical records, and was likely to injure the residents in that subsequent care givers would not have complete information to base their decisions for further care.

8. On or about May 12, 2015, through November 8, 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to complete Minimum Data Set (MDS) assessments within fourteen (14) days of admission for Residents SS and RR, Comprehensive assessments every twelve (12) months for Residents TB and JG, and Quarterly assessments for Residents TB, SS, OB, and RR. Respondent's conduct was likely to injure the residents from clinical care decisions based upon incomplete assessment information.

9. On or about July 13, 2015, through September 14, 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to develop and/or revise an accurate and comprehensive care plan based on the assessment of Resident JW. Respondent's conduct was likely to injure the resident from clinical care decisions based upon inaccurate assessment information.

10. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed

to ensure that monthly orders were reviewed and signed by the physician for Residents SS, JW, OB, JG, TB, RR, HE, RS, KA, and LD. Respondent's conduct exposed the residents to a risk for harm in that the physician's orders were not up to date.

11. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the staff she was administratively responsible for maintained the privacy, confidentiality, and promoted the dignity and respect of Residents JW, JG, DC, LW, HE, and CY. Respondent's conduct exposed patients to risk for emotional harm related to lack of privacy.

12. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the staff she was administratively responsible for managed, and stored medications in a safe manner, and administered medications to Residents RR, RS, JW and JG, as ordered by the physician. Respondent's conduct exposed patients to risk for harm related to an unsafe environment and medication errors and/or adverse reactions.

13. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the staff she was administratively responsible for maintained infection control measures for Residents JW, TB, and JG. Respondent's conduct exposed patients to risk for harm related to infectious pathogens.

14. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the staff she was administratively responsible for, documented accurately and/or completely in the medication records of Residents RR, RS, JW, and JG. Respondent's conduct contributed to an inaccurate medical records and was likely to injure patients from clinical care decisions based upon inaccurate and/or incomplete assessment information

15. On or about November 2015, through December 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the staff she was administratively responsible for, notified the physician of the abnormal lab results of Resident JW. Respondent's conduct and deprived the physician of information which would be required to institute timely medical interventions and was likely to injure the patient from medical complications and pharmaceutical interactions including hemorrhage.

16. On or about December 15, 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the certification of her staff was up to date in that a Medication Aide's certification expired on December 13, 2015. Respondent's conduct exposed residents to risk for harm related to medication administration by unlicensed/uncertified personnel.

17. On or about December 15, 2015, through December 17, 2015, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent failed to ensure that the facility was sufficiently staffed to meet the needs of Residents JW and JG, as indicated by care plans. Respondent's conduct exposed the residents to harm related to unmet needs and/or unsafe conditions.

18. On or about July 1, 2016, through October 7, 2016, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent worked twenty-four (24) hours a day, seven (7) days a week, for periods as long as ten (10) days, and slept from approximately 11:00pm until 5:00am while she was the only licensed staff member for more than twenty (20) residents. As the only licensed nurse on duty for sixty-two (62) out of ninety-seven (97) days, Respondent's time worked totaled 1979.2 hours. Respondent's conduct could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing patients in potential danger.

19. On or about October 5, 2016, while employed as the Owner/Director of Nursing at Littlefield Hospitality, Littlefield, Texas, Respondent lacked fitness to practice nursing in that Respondent was observed sleeping while on duty and as the only licensed nurse on premises, and had to be awakened by the CNA on duty when a Department of Aging Disability Services surveyor entered the facility to conduct an investigation. Respondent's conduct could have affected her ability to recognize subtle signs, symptoms, or changes in residents' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the residents in potential danger.

20. In response to Findings of Fact Numbers Seven (7) through Nineteen (19), Respondent admits to late submission of patient data and the late completion and submission of assessments. Respondent further states that the care plan for Resident JW was updated on March 23, 2015, July 13, 2015, and September 24, 2015. Regarding the review of monthly orders, Respondent states that she personally hand delivered orders for signature to the physician's office at the end of each month, but had difficulty obtaining his signature in a timely manner. Respondent further states that policies and procedures were in place and that staff training was done regarding privacy, confidentiality, the promotion of dignity and respect for the residents, and infection control. In addition, Respondent states that medication policy and procedures were in place, medication was stored either in the locked medication room or in the locked medication cart, and that staff was trained in the timely administration and documentation of medication. Respondent further states that she called the physician's office about the slightly abnormal INR level for Resident JW, but he did not respond, and in her nursing judgment, it was not a cause for concern. Regarding the expired certification of her nursing staff, Respondents states that the employee lied about the expiration date and having already taken the class for renewal. Respondent states when she discovered that she was misled, she immediately prohibited the employee from administering medications. Regarding the care plans for Residents JW and JG, Respondents states there

was always at least two (2) direct care staff (combination of licensed and unlicensed) on duty without exception and that staffing met the needs of patient care plans. Regarding her work hours, Respondent states that the only other option would have been voluntary closure, which would have displaced the patients who were difficult to place due to both behavioral and psychological disorders. Respondent further states that the location of the facility in a very small town gave her a limited pool of potential employees and she was unable to hire additional staff.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555 , the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C),(1)(D),(1)(M),(1)(P),(1)(T),(1)(U),(1)(V)&(3) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(1)(E),(2),(4)&(5).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10),(12)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 838381 and Vocational Nurse License Number 186514, heretofore issued to KRISTI DENISE PORTER, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 838381 and Vocational Nurse License Number 186514, previously issued to KRISTI DENISE PORTER, to practice nursing in Texas are hereby **SUSPENDED** with the suspension **STAYED** and Respondent is hereby placed on **PROBATION,** in accordance with the terms of this Order, for a minimum of two (2) years **AND**

until Respondent fulfills the requirements 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.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to 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. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders," which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: *http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp*. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

IV. 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.

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.

C. **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.

D. **The course "Delegating Effectively,"** a 4.2 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.*

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This

requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this 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. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of the stipulation/probation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and

predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **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 individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

VI. FURTHER COMPLAINTS

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

VII. 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.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that when this Order becomes final and the terms of this Order become effective, a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including possible revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 28 day of August, 2017.

KRISTI DENISE PORTER, Respondent

Sworn to and subscribed before me this 28th day of August, 2017.

SEAL

MARY F. LARA
Notary Public, State of Texas
Comm. Expires 07-23-2020
Notary ID 10975796

Notary Public in and for the State of TX

Approved as to form and substance.

Benjamin Garcia, Attorney for Respondent

Signed this 28th day of August, 2017.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 28th day of August, 2017, by KRISTI DENISE PORTER, Registered Nurse License Number 838381 and Vocational Nurse License Number 186514, and said Order is final.

Effective this 26th day of October, 2017.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board