

Respondent's nursing employment history continued:

11/2003 - 2/2006	Agency Staff Nurse	Memorial Hermann Houston, Texas
2/2006 - 2/2007	Staff Nurse	Akron General Medical Center Akron, Ohio
3/2007 - 10/2007	Psychiatric Nurse	Laurelwood Psychiatric Hospital Unknown
1/2007 - 7/2007	Staff Nurse	Hospice of Western Reserve Cleveland, Ohio
10/2007 - 8/2008	Travel Staff Nurse	Conroe Medical Center Conroe, Texas
8/2008 - 5/2010	Charge Nurse	HealthSouth Rehabilitation Hospital Unknown
5/2010 - 10/2010	Director of Nursing (DON)	Daybreak Venture Unknown
11/2010	Unknown	
12/2010 - 9/2011	DON	Villa Toscana Rehab & Skilled Nursing Houston, Texas
11/2010 - 3/2011	Staff Nurse	Pinard Hospice Spring, Texas
10/2011 - 7/2012	Not working as a Nurse	
8/2012 - 7/2014	Agency Staff Nurse	ProHealth Staff Nursing Unknown
9/2013 - 8/2014	Nursing Supervisor	Atwell Home Health Services Houston, Texas
12/2013 - 8/2014	DON	Embrace Home Health Care, Inc. Houston, Texas

Respondent's nursing employment history continued:

8/2014 - Present	PRN Immunization Nurse	All Medical Staffing Unknown
2/2015 - 9/2015	Travel Staff Nurse	Liquid Agents Plano, Texas
9/2015 - 9/2016	Nurse Director	A-Tap Inc. Houston, Texas
8/2016 - 9/2016	Staff Nurse	Avatar Home Health and Hospice Spring, Texas
10/2016 - Present	Unknown	

6. At the time of the incident in Finding of Fact Number Seven (7), Respondent was employed as the Nurse Director with A-Tap Inc., a home and community service (HCS) provider, Houston, Texas, and had been in that position for less than one (1) month.
7. On or about September 2015, through January 28, 2016, while employed as the Nurse Director with A-Tap Inc., a home and community service (HCS) provider, Houston, Texas, Respondent failed to ensure that a medication administration record (MAR) for Residents NM and DM was in the group home where their medications were administered by care staff. The MAR provides the list of current medications that the physician has ordered for the residents that the care staff administer to the residents. In addition, on or about September 2015, through November 12, 2015, Respondent failed to delegate medication administration to the unlicensed care staff, and failed to monitor and evaluate their performance. Respondent's conduct was likely to injure the residents from a lack of appropriate nursing care.
8. On or about September 2015, through October 25, 2015, while employed as the Nurse Director with A-Tap Inc., an HCS provider, Houston, Texas, Respondent failed to update the MAR of Resident NM to reflect an increase in his Divlprovex Sodium from 250 mg to 500 mg. Respondent's conduct was likely to injure the resident in that subsequent care givers would rely on her documentation to further medicate the patient.
9. On or about September 2015, through February 12, 2016, while employed as the Nurse Director with A-Tap Inc., an HCS provider, Houston, Texas, Respondent failed to perform a fall risk assessment of Resident NM, who had an unsteady gait and a history of falls. Respondent's conduct was likely to injure the resident from ineffective treatment in that care givers would rely on her assessments to provide care.

10. On or about September 2015, through February 12, 2016, while employed as the Nurse Director with A-Tap Inc., an HCS provider, Houston, Texas, Respondent failed to create a MAR for Resident JM. Respondent's conduct was likely to injure the resident from lack of appropriate nursing and medical care.
11. On or about October 15, 2015, through October 25, 2015, , while employed as the Nurse Director with A-Tap Inc., an HCS provider, Houston, Texas, Respondent failed to update the MAR of Resident DM when there were medication changes. Respondent's conduct was likely to injure the resident in that subsequent care givers would rely on her documentation to further medicate the patient.
12. On or about October 20, 2015, while employed as the Nurse Director with A-Tap Inc., an HCS provider, Houston, Texas, Respondent completed a comprehensive nursing assessment for Resident JM without reviewing prior assessments, was unaware that the aforementioned resident had asthma and used an inhaler, and failed to ensure that the resident had an inhaler in the group home where he resided. Respondent's conduct resulted in an incomplete medical record, and was likely to injure the resident from clinical care decisions formulated based upon incomplete assessment information.
13. In response to the incidents in Findings of Fact Numbers Seven (7) through Twelve (12), Respondent states that on November 13, 2015, she trained the staff and delegated responsibility for medication administration. Respondent states that she was only allowed limited access to the group home by the House Manager, so she was unable to evaluate the unlicensed care staff in medication administration. Respondent states that regarding Finding of Fact Eight (8), the inaccurate MAR was a timing issue. Respondent states that the MAR on site with the resident was updated to reflect the Divlprovex Sodium 500mg dosage while the office Nursing Assessment hadn't been updated. Respondent explains that both documents have since been aligned. Respondent states that regarding Finding of Fact Nine (9), both the resident's doctor's orders and the staff monitoring notes indicate that no falls were suffered in the past year. Respondent states that a fall risk assessment was since completed. Respondent states that regarding Finding of Fact Twelve (10), at the time of her hire, a MAR was already in place, and that she continued to use it while developing an enhanced version. Respondent indicates that a new version of the MAR was implemented on January 29, 2016. Respondent states that regarding Finding of Fact Thirteen (11), this was a clerical error, and no incorrect medication was administered to Resident DM. Respondent states that the MAR was updated on January 29, 2016. Respondent states that regarding Finding of Fact Fourteen (12), according to the resident and staff, the resident had been asymptomatic, and as a result, the January 29, 2016 doctor's orders prescribed no asthma medication.
14. On or about November 26, 2016, Respondent successfully completed a class in clinical documentation for home health.
15. On or about December 16, 2016, Respondent successfully completed a Board approved class in nursing documentation, which would have been a requirement of this Order.

16. On or about December 17, 2016, Respondent successfully completed a Board approved class in Texas nursing jurisprudence and ethics, which would have been a requirement of this Order.
17. On or about January 8, 2017, Respondent successfully completed a Board approved class in Sharpening Critical Thinking Skills, which would have been a requirement of this Order.
18. On or about January 29, 2017, Respondent successfully completed a Board approved class in physical assessment, which would have been a requirement of this Order.

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)(D),(1)(M),(1)(P),(1)(U)&(3)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(1)(F)&(4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 698549, heretofore issued to MARCHELLE DIANE LEE.
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 that RESPONDENT SHALL receive the sanction of **WARNING WITH STIPULATIONS** in accordance with the terms of this Order.

- A. This Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.
- B. This Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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

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. 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 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. 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 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 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.

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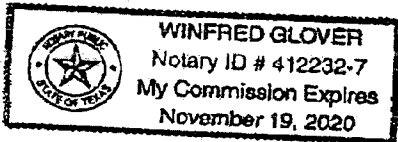
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RESPONDENT'S CERTIFICATION

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 12th day of September, 2017.
Marchelle Diane Lee
MARCHELLE DIANE LEE, Respondent

Sworn to and subscribed before me this 12 day of September, 2017.



SEAL

Winfred Glover
Notary Public in and for the State of TEXAS

Approved as to form and substance.

Taralynn R. Mackay
Taralynn R. Mackay, Attorney for Respondent

Signed this 18th day of September, 2017

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 12th day of September, 2017, by MARCHELLE DIANE LEE, Registered Nurse License Number 698549, and said Order is final.

Effective this 26th day of October, 2017.

A handwritten signature in black ink, appearing to read "Katherine A. Thomas". The signature is written in a cursive style with a horizontal line underneath it.

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