DOCKET NUMBER 507-19-4959

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 188481, ISSUED TO THEODORA NNEKA ANYASINTI	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: THEODORA NNEKA ANYASINTI
3734 BRIGHTON SPRINGS LN.
KATY, TX 77449

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 23-24, 2020, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and 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 recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

The Board agrees with the ALJ that the Respondent's conduct warrants a third tier, level I sanction for his violations of §301.452(b)(10) and (13).[1] Licensure revocation is authorized by the Board's Disciplinary Matrix[2] for a third tier, sanction level I violation of §301.452(b)(10). Either licensure revocation or licensure suspension is authorized by the Board's Disciplinary Matrix for a third tier, sanction level I violation of §301.452(b)(13). In this case, the Board agrees with the ALJ that licensure revocation is the most appropriate sanction.

Respondent failed to intervene during the patient's respiratory distress.[3] The Respondent's conduct was serious in nature, as it caused severe and actual harm to a vulnerable patient.[4] Further, Respondent has three prior Board orders; one in 2008; one in 2009; and one in 2017.[5] The Respondent failed to show any mitigating standards that apply to her conduct.[6]

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33, that licensure revocation is the most appropriate sanction in this matter.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 188481, previously issued to THEODORA NNEKA ANYASINTI, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

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

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

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[1] See page 15 of the PFD.

[2] See 22 Tex. Admin. Code §213.33(b).

[3] See adopted Finding of Fact Number 19.

[4] See page 14 of the PFD and adopted Finding of Fact Number 23.

[5] See page 15 of the PFD and adopted Finding of Fact Number 24.

[6] See adopted Finding of Fact Number 25.

Entered this 23rd day of January, 2020.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; Docket No. 507-19-4959 (October 8, 2019)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

October 8, 2019

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

RE: Docket No. 507-19-4959; Texas Board of Nursing v. Theodora Nneka Anyasinti, LVN

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, a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,

Pratibha J. Shenoy
Administrative Law Judge

PS/tt
Enclosures

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA INTERAGENCY**
Elizabeth Tschudi, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA INTERAGENCY**
Theodora N. Anyasinti, 3734 Brighton Springs Ln., Katy, TX 77449 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-19-4959

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
THEODORA N. ANYASINTI, LVN **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks revocation of the Licensed Vocational Nurse (LVN) credential held by Theodora N. Anyasinti (Respondent) based on alleged documentation and standard of care deficiencies in her care of a pediatric patient (Patient), who later died. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the most serious of its four charges and, for the reasons set forth herein, recommends that the Board revoke Respondent's license.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here. ALJ Pratibha J. Shenoy convened the hearing on the merits at the State Office of Administrative Hearings (SOAH) facility in Austin, Texas, on August 19, 2019. Assistant General Counsel John Vanderford represented Staff. Respondent appeared and represented herself.[1] The record closed at the end of the hearing that day.

II. APPLICABLE LAW AND STAFF'S CHARGES

The Texas Nursing Practice Act, found in chapter 301 of title 3, subtitle E of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, failure to meet minimum standards of nursing practice (pursuant to Code § 301.452(b)(13)) or unprofessional conduct (under Code § 301.452(b)(10)). Staff asserts that Respondent's conduct

[1] On August 8, 2019, attorney Pauline C. Ike filed a letter announcing that she was withdrawing from representation of Respondent. At the hearing, Respondent acknowledged that she was proceeding as a self-represented litigant.

is grounds for disciplinary action under both Code provisions, as well as pursuant to Board Rules 217.11 and 217.12.[2]

Board Rule 217.11 addresses minimum standards of nursing practice, and Staff alleged Respondent is subject to sanction under six provisions:

- **Board Rule 217.11(1)(A)**: Failure to know and conform to the Code and Board rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of practice;
- **Board Rule 217.11(1)(B)**: Failure to implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(C)**: Failure to know the rationale for and the effects of medications and treatments and correctly administer the same;
- **Board Rule 217.11(1)(D)**: Failure to accurately and completely report and document required matters, including client status, nursing care rendered, and administration of medications and treatments;
- **Board Rule 217.11(1)(M)**: Failure to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications; and
- **Board Rule 217.11(1)(P)**: Failure to collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care.

Staff also alleges four violations of Board Rule 217.12, which addresses unprofessional conduct:[3]

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;

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[2] For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, shall be referred to as "Board Rule ____."

[3] Board Rule 217.12(1)(B) and (4) were revised effective February 25, 2018. The amendments removed the words "carelessly or repeatedly" before "failing" in Board Rule 217.12(1)(B) and the words "careless or repetitive" before "conduct" in Board Rule 217.12(4). Also deleted from Board Rule 217.12(4) was the sentence, "Actual injury to a client need not be established." Staff's allegations span the time period from December 13, 2017 to October 26, 2018. The most serious of Staff's allegations concerns care rendered on October 26, 2018; therefore, this Proposal for Decision (PFD) cites the current versions of Board Rule 217.12(1)(B) and (4).

- **Board Rule 217.12(1)(B)**: Failing to conform to generally accepted nursing standards in applicable practice settings;
- **Board Rule 217.12(1)(C)**: Improper management of client records; and
- **Board Rule 217.12(4)**: Conduct that may endanger a client's life, health, or safety.

When a nurse has violated the Code or Board rules, the Board is required to impose a disciplinary sanction.[4] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[5] The Disciplinary Matrix categorizes violations into tiers, and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. The Disciplinary Matrix also lists certain aggravating and mitigating factors that must be considered. Board Rule 213.33 includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[6] Staff had the burden of proving its allegations by a preponderance of the evidence.[7]

Staff charges that Respondent engaged in the following conduct in violation of Board rules (the specific acts are discussed further in the next section):

- **Charge I**: Between December 13, 2017, and October 26, 2018, Respondent failed to perform respiratory assessments and/or document respiratory assessments before and after suctioning Patient's tracheostomy;
- **Charge II**: Between December 13, 2017, and October 26, 2018, Respondent failed to follow proper procedure for suctioning Patient's tracheostomy in that she exceeded the limit of three passes during the suction treatment;
- **Charge III**: On October 26, 2018, Respondent failed to implement physician's emergency orders for symptoms of respiratory distress, failed to initiate cardiopulmonary resuscitation (CPR), and failed to timely activate emergency medical services (EMS) when Patient experienced respiratory distress and subsequent cardiopulmonary arrest. In addition, Respondent was not forthcoming with patient information needed by EMS; and

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[4] Code § 301.453; Board Rule 213.33(e)

[5] Board Rule 213.33(c).

[6] Board Rule 213.33(c).

[7] 1 Tex. Admin. Code § 155.427.

- **Charge IV**: On October 26, 2018, Respondent failed to document findings and interventions performed when Patient experienced respiratory distress and subsequent cardiopulmonary arrest, resulting in an incomplete medical record.

III. DISCUSSION

A. Undisputed Facts

Respondent did not contest most of the specifics of Staff's charges, but testified regarding the context and the reasons for her conduct. Staff offered nine exhibits that were admitted without objection.[8] Respondent did not offer documentary evidence. Staff called as witnesses Patient's parents (Mom and Dad),[9] who themselves are nurses, and offered the expert testimony of Kristen Sinay, RN, who is a nursing practice consultant to the Board.[10] The following discussion presents the undisputed facts, followed by testimony regarding disputed matters. Ms. Sinay's testimony is discussed partly in this section and partly in the Analysis section.

Dad became a licensed nurse in 1998. He has worked in emergency rooms, intensive care units (ICUs), and cardiothoracic care, and currently works in a telemetry/intermediate care ward. He testified that Patient was born healthy but contracted meningitis when he was only 28 days old. Although Patient survived, he suffered a traumatic brain injury and contended with developmental delays, seizure disorder, hypothyroidism, and, most critically, respiratory issues. Patient relied on a ventilator to breathe. He was unable to see or speak but responded to voices and touch.

When Patient was born, the family lived in New York, and Patient was cared for in a facility that was very expensive. In 2017, Mom and Dad moved to Houston so they could afford to buy a house and care for Patient at home. Shortly after the move, Patient was admitted to the hospital due to prolonged seizures. At that time, Patient underwent a tracheostomy. Dad explained that in

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[8] Staff Exs. 1-8 and 3a; Staff's Demonstrative Exhibit 9 is included for reference but was not offered or admitted as evidence.

[9] To further safeguard Patient's privacy, this PFD refers to Patient's parents as Mom and Dad. Witnesses who are personally familiar with a patient can find it very difficult to avoid accidentally using the patient's name, and SOAH does not have the capacity to edit audio records of its hearings. Therefore, the ALJ allowed the witnesses to use Patient's name and the audio recording of the hearing was sealed.

[10] Ms. Sinay's qualifications were discussed on the record, and she was accepted by the ALJ as an expert on nursing practice without objection from Respondent.

lay terms, a tracheostomy is a surgical procedure to insert a tube that creates "a shortcut from the trachea to the lungs." Patient required a caregiver with specialized skills, including expertise in managing the ventilator and the ability to handle respiratory emergencies.

According to Dad, a tracheostomy must be suctioned if it becomes blocked by phlegm or other secretions. Extra oxygen should be administered after suctioning. Dad noted that a healthy person has an oxygen saturation of at least 90%. It was very important to intervene immediately to administer oxygen if Patient began to "de-saturate" below 88%, because his low lung reserve meant he could continue to de-saturate very rapidly and could stop breathing. Dad said the home health agency that employed Respondent advised Mom and Dad that Respondent was certified to handle all of Patient's equipment and had the necessary background and experience. Regardless, when Respondent first came to care for Patient, Dad repeatedly went over the instructions for oxygen administration and suctioning with her, just as he did with all of Patient's nurses.

Dad said he is accustomed to having cameras present in healthcare environments. He testified that, to protect both Patient and the nurses who cared for Patient, he installed a camera in Patient's bedroom that captured a full head-to-toe view of Patient as he was lying in bed. A recording from the night of October 26, 2018, taken from the bedroom camera, was admitted into evidence and played during the hearing, with testimony from Mom and Ms. Sinay.[11] The video does not have accompanying audio. Patient's nurses were aware of the camera.

Mom is an adult ICU nurse, and she and Dad arranged their work shifts so that one of them was always home in addition to Patient's nurse. On October 26, 2018, Mom had taken Patient to have a granuloma near his feeding tube cauterized.[12] The doctor told Mom to leave the area covered with gauze for 24 hours to avoid bleeding at the cauterization site. Mom added that Patient's heart rate usually went down when he was taken out of the home, due to his difficulty maintaining his body temperature. However, he was back to normal by the time they returned home around 6:00 p.m. Respondent was the nurse on duty that night. Mom said she always told the nurses, as they came onto their shifts, if anything had happened that day and how Patient was

[11] Staff Ex. 8.

[12] Mom explained the granuloma was a tissue growth resulting from Patient's skin being irritated by the feeding tube inserted in his stomach.

doing. Mom told Respondent that the gauze on Patient's stomach should not be disturbed, but that Patient was otherwise doing fine.

Around 1:00 a.m., Mom went to bed. She said she woke up between 4:20 and 4:30 a.m. when she heard Respondent yell, "Mom, Mom, come here!" Mom ran to Patient's room and immediately saw Patient was "very blue" and his pulse oximeter showed an oxygen saturation of 40% and a pulse rate of 20. Mom said, "What did you do?" to Respondent, and started to intervene. Mom told Respondent to call 911 right away. Reviewing the video during the hearing, Mom testified that the pulse oximeter was flashing, a clear sign to any nurse that a patient is out of normal range. Patient's levels indicated he was at risk of immediate cardiac arrest.

Mom told Respondent to get the ambu (resuscitation) bag. When Respondent retrieved it, Mom placed it over Patient's tracheostomy site and began using it to manually ventilate Patient. Mom also directed Respondent to get the oxygen tank; Mom noted that Respondent got the tank in place, but did not turn it on immediately. Mom started CPR while continuing to use the ambu bag on Patient, and Respondent called 911. The first responders took over CPR when they arrived, and transported Patient to the emergency room. Patient passed away at the hospital.

Reviewing the video from Patient's room, Ms. Sinay testified that Patient was showing signs of distress well before Respondent called for Mom's help. Ms. Sinay pointed out that Patient jerked when Respondent administered suction to his tracheostomy, threw his head back, and was starting to look purple, all indications that he was struggling to breathe. The pulse oximeter was already flashing, which Ms. Sinay said should have prompted Respondent to attach the ambu bag immediately and call 911. Instead, Respondent appeared to be "fiddling with [Patient's] blankets and checking the tracheostomy site." Ms. Sinay opined that Respondent should have recognized the urgency of the situation, given that "time is brain." The adage refers to the fact that after four to six minutes without oxygen, irreversible brain damage will occur.

Ms. Sinay personally found the video "very upsetting" to watch because, even after Mom entered the room, Respondent: was not assisting Mom with CPR, which ideally is a two-person activity; she "circled the bed several times" without a purpose; and she brought in the oxygen tank but did not appear to connect it properly. Ms. Sinay pointed out that Respondent's cell phone

screen is visible on the video, and she appeared to scroll through several screens and even put the phone down at one point before finally calling 911. Nearly five minutes passed before she made the call. Furthermore, Respondent held the phone to her ear, whereas if she had used the speaker, she would have had her hands free to help Mom.

Although Mom and Dad are experienced nurses, their primary role was that of parents when it came to Patient, Ms. Sinay stated. Even parents who are healthcare professionals cannot be expected to have clear judgment when their child is in distress. Respondent's responsibility was to be the healthcare provider and perform the interventions in an objective and calm manner. Instead, in Ms. Sinay's opinion, the most useful thing Respondent did was to call Mom to the room, because Mom was the only one who provided critical care.

Ms. Sinay said Respondent's most egregious conduct was her failure to intervene quickly and effectively on October 26, 2018. However, Ms. Sinay pointed out other problems with Respondent's practice. First, a nurse should assess and document a patient's breath sounds, heart rate, respiratory rate, and oxygen saturation both before and after suctioning a tracheostomy. The documentation was required by Respondent's employer, Epic Health Services (Epic). Even if Epic did not require it, Ms. Sinay said, the assessment is a minimum standard of care because it allows a nurse to evaluate whether suctioning successfully eased the patient's breathing. Documentation is a minimum standard both to show that the care was given and to provide continuity of care. Looking at the records Respondent prepared during her time caring for Patient (December 2017 to October 2018), Ms. Sinay identified a number of instances in which she found the documentation was missing.[13]

A second problem identified by Ms. Sinay is that Respondent routinely made more than three "passes" when suctioning Patient. Each time the suction catheter is inserted into the tracheostomy counts as a "pass" and the number of passes is limited because each pass irritates the

[13] Staff's Exhibit 5 includes over 5,000 pages of medical records maintained by Epic Health Services, and includes records prepared by all of Patient's home health nurses, not just Respondent. To assist the ALJ, Staff prepared Demonstrative Exhibit 9, highlighting the records that supported each of its four charges against Respondent. Staff has the burden of proof in this case. While the ALJ has independently reviewed some of the documents in Staff's Exhibit 5, Staff was advised during the hearing that specific reference needed to be made to the pages that Staff relied on for its proof. The Analysis section discusses the ALJ's findings regarding where Staff's proof fell short.

airway and creates a risk of vasospasm in the throat. In response to Respondent's testimony that multiple passes were often required to clear Patient's tracheostomy, Ms. Sinay said that the correct procedure would have been for Respondent to ask for additional physician's orders allowing the extra passes, and to document the new orders in the record.

Finally, Ms. Sinay opined that, based on the narrative prepared by the Fort Bend EMS staff who responded on October 26, 2018, Respondent did not cooperate in conveying important information to EMS so that they could better care for Patient. The narrative states in relevant part:

> Called to home [for Patient] that had gone into respiratory arrest. Call taker was unable to get feedback about CPR being performed. . . . RN at scene reported she was suctioning [Patient] when she noticed a problem. [Patient] had turned blue. Mom was on scene and started CPR. . . . Information at scene had to be attempted to be gathered multiple times and RN was not forthcoming with info. Mom was doing compressions on [Patient] upon contact.[14]

Ms. Sinay commented that the EMS dispatcher and responders apparently believed Respondent was an RN, not an LVN. However, Ms. Sinay said, it is clear that "RN" in the note refers to Respondent, because Respondent was the one who suctioned Patient, and Mom was the one who was performing CPR.

B. Disputed Matters

At the hearing, Mom and Dad described their working relationship with Respondent very differently from how Respondent characterized it. Dad said that he was growing concerned about Respondent's fitness as a nurse because Respondent was slow to react to signs that Patient was in distress. Dad cited an incident on October 20, 2018, when he saw that Patient's oxygen saturation had fallen to 87% but Respondent continued to change Patient's diaper instead of responding. According to Dad, Respondent said "Patient was ok because his color was not changing" even when Dad reminded Respondent that Patient was fragile and could de-saturate rapidly, leading to cardiac arrest. The incident at issue in this case occurred just a week later (October 26, 2018).

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[14] Staff Ex. 6 at 6.

Dad said that he wanted to tell Epic not to send Respondent to care for Patient any more, but Mom "has a good heart" and felt bad that Respondent was going through a lot in her personal life. Respondent's husband was on dialysis, her mother had suffered a stroke, and she was in financial difficulty. Mom testified that she was "close to giving up" when Respondent started "being rude," but Mom "pitied" Respondent and felt that—because she and Dad were both nurses and one of them was always at home—it was OK to give Respondent more chances.

Dad added that he was unaware of Respondent's three prior Board Orders until he looked up Respondent's record on the Board's website after Patient passed away.[15] If he had known, he would not have allowed Respondent to care for Patient. Both Mom and Dad testified that their professional experience as nurses, as well as their deep grief over losing their son, motivated them to file a complaint against Respondent with the Board so that others would not suffer from Respondent's sub-standard practice. They denied Respondent's testimony (discussed below) that they were facing financial problems, they wanted to sue Respondent's employer, and that there was a "rotten smell" on the date Patient had his respiratory arrest.

For her part, Respondent challenged why Mom and Dad would continue to employ her if they did not trust her nursing skills. She found the work environment at Mom and Dad's house very stressful. Respondent said that Dad would get so upset when Patient vomited that she felt "scared" and was inhibited in providing care to Patient. Respondent acknowledged that vomiting could lead to aspiration pneumonia if Patient accidentally aspirated food into his lungs. However, she was preoccupied with worry about Dad's reactions and that made it difficult to work.

Respondent also questioned what might have been going on financially for Mom and Dad. She said they told her their bills were high after they purchased their home, and they were worried about money. Respondent noted that "the handwriting was on the wall" and she believed Mom and Dad were "waiting for her to make a mistake" so they could sue Epic (the home health agency). Even though Respondent "stopped being comfortable" with Mom and Dad, she kept working for them because they were "still good people" and she "had a relationship" with them.

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[15] Respondent's prior Board Orders are discussed in the Analysis section.

On October 26, 2018, Patient's day nurse cautioned Respondent to "monitor the bleeding." According to Respondent, this was a reference to the cauterization procedure Patient had undergone that day. Respondent felt that Mom was being an obstacle to Respondent's ability to provide proper nursing care because Mom told Respondent not to touch the gauze at the cauterization site. Respondent said she needed to visualize the area to be sure that there was no "general bleed," but Mom thwarted her. In addition, Respondent testified, there was a "rotten smell" coming from Patient that she had not observed before. Respondent said Mom also noticed the smell but rejected Respondent's concern that it was coming from the cauterization site.

While caring for Patient around 4:00 a.m., Respondent said, she turned off his feeding tube to prepare for a breathing treatment. She suctioned Patient's tracheostomy, and noticed "a slight color change," which prompted her to call for Mom. As the emergency unfolded, Respondent found it "difficult to concentrate" because "Mom was panicking." Nonetheless, Respondent acknowledged that Patient was her responsibility. She said she "froze" and conceded that she did not intervene by performing CPR and quickly calling 911.

Respondent disputed that she was not forthcoming in providing information to the EMS staff. She insisted she was cooperative and did what she was asked to do. With respect to documenting care on October 26, 2018, Respondent said she left the home when Patient was taken to the hospital and returned to Epic's offices, but she was not allowed access to the charting program she needed to finish her records.

Respondent acknowledged that she has three prior Board Orders, issued in 2008, 2009, and 2017. She pointed out that she successfully completed the terms of all three orders. Respondent stated that for the first two orders, she did not retain an attorney. She said that if she "had known better," the third order "might have been [her] first," and she would not be in the situation of having "all of it piled up and counting against [her]."

C. Analysis

As previously noted, Staff submitted over 5,000 pages of medical records prepared by all of Patient's home health nurses, not just Respondent. The ALJ advised Staff that, to meet its

burden of proof in this case, it needed to provide citations to specific pages within the medical records. Staff's Demonstrative Exhibit No. 9 highlighted the records Staff believed were pertinent to each charge.

1. Charge I: Failure to Perform/Document Respiratory Assessments

For Charge I, Staff asserted that certain records demonstrated Respondent's failure to assess and/or document Patient's breath sounds, heart rate, respiratory rate, and oxygen saturation both before and after suctioning a tracheostomy.[16] Having reviewed the records specified by Staff, the ALJ cannot find evidence that Respondent failed to make proper assessments of Patient.

Further, the ALJ is unable to determine the manner in which Respondent fell short in her documentation of these assessments. For example, Staff cited an overnight shift Respondent worked that started on the evening of October 19, 2018.[17] The records indicate that Respondent documented heart rate, respiratory rate, and oxygen saturation for Patient at least four times during the shift, including before and after the times tracheal suction is documented.[18] Also, Respondent included a narrative note that the shift was uneventful except that *after treatment*, Patient "[de-saturated] to 87%" and after an intervention, Patient "eventually improved" to 99%.[19] For purposes of Charge I, the note indicates Respondent *did* document relevant assessments. The other instances cited by Staff are similarly unclear. Therefore, the ALJ finds that Staff did not meet its burden of proof to establish Charge I.

2. Charge II: Exceeding Limit of Three Passes During Suction Treatment

Staff's Demonstrative Exhibit No. 9 cites several pages of records reflecting that Respondent frequently performed four passes during suction treatment of Patient's tracheostomy, as illustrated by her notation of "Tracheal Suction Frequency:: X4."[20] On one occasion,

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[16] Staff Ex. 9 at 1-2.

[17] Staff Ex. 9 at 1, citing Staff Ex. 5, "Hope 10/2018 Part 2," at 93.

[18] Staff Ex. 5, "Hope 10/2018 Part 2," at 84-85.

[19] Staff Ex. 5, "Hope 10/2018 Part 2," at 93.

[20] Staff Ex. 9 at 3.

Respondent documented five passes. Staff also pointed out that Epic's policy is that the nurse should "[l]imit each suction treatment to no more than three passes."[21] However, upon inspection, the ALJ found several instances of other nurses also exceeding three passes. On October 13, 2018, Theresa Brown, RN, documented "Tracheal Suction Frequency:: X7 on this shift."[22] Ms. Brown performed six passes on October 15[23] and again on October 22, 2018.[24] Another nurse, Mariela Ramirez, RN, documented "Tracheal Suction Frequency:: X4" on October 23, 2018.[25]

Ms. Sinay testified that if Patient required more than three passes to clear his tracheostomy, Respondent should have obtained additional doctor's orders and documented them in the record. It is unclear whether such doctor's orders existed. In the absence of evidence that Respondent's use of four passes (and five passes on one date) was against doctor's orders, and given the practices of other nurses caring for Patient, the ALJ cannot find that Respondent violated proper procedure or policy. Therefore, the ALJ finds that Staff did not meet its burden of proof to establish Charge II.

3. Charge IV: Failure to Document Findings and Interventions for Patient's Respiratory Distress and Cardiopulmonary Arrest on October 26, 2018[26]

Based on the October 26, 2018 video from Patient's bedroom, it is clear that events progressed rapidly from the time Patient's monitors first began flashing to the time EMS transported him to the hospital. Ms. Sinay stated that the priority for a nurse is to administer lifesaving care first and to address documentation later, after an emergency has been handled. She added that she did not believe Respondent should have been charting the nursing care while Mom was administering first aid. Rather, Respondent should have been in charge of (or at a minimum, should have assisted Mom with) performing CPR and calling 911 immediately. The chart should have been completed once EMS took over care for Patient.

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[21] Staff Ex. 5, "TNA Policies," at 18.

[22] Staff Ex. 5, "Hope 10/2018 Part 2," at 18.

[23] Staff Ex. 5, "Hope 10/2018 Part 2," at 194.

[24] Staff Ex. 5, "Hope 10/2018 Part 2," at 128.

[25] Staff Ex. 5, "Hope 10/2018 Part 2," at 141.

[26] Charge III is the most serious charge and is discussed last.

Respondent acknowledged that she has a duty to maintain records of her assessments and interventions for Patient's care. Respondent's testimony is that she did not have access to the Epic recordkeeping system after Patient was taken to the hospital. Nothing in evidence contradicts her position. Staff did not demonstrate that Respondent failed to maintain records because Staff did not prove she had access to the information or recordkeeping system that she needed to use in order to complete Patient's records. Therefore, the ALJ finds Staff did not meet its burden of proof on Charge IV.

4. Charge III: Failure to Initiate CPR, Timely Activate EMS, and Provide Information to EMS

Respondent admitted that she "froze" and did not take the steps she knew were necessary to address Patient's distress, including calling 911 right away and starting CPR. As Ms. Sinay pointed out, Patient was having trouble breathing when Respondent suctioned his tracheostomy and his pulse oximeter was flashing even before Respondent decided to call Mom for help. Despite Mom's testimony that she told Respondent multiple times to call 911, nearly five minutes passed between the time Mom came into the room and the time Respondent called for EMS. Respondent did not start CPR; Mom did. Respondent was slow to call despite having a cell phone in her hand, and she did not take the logical step of putting the phone on speaker so she could help Mom while talking to EMS.

Respondent blamed what she felt was a stressful work environment for her lapses in providing care. However, Ms. Sinay testified that each nurse has the responsibility to maintain clear boundaries with patients and their families, which is especially important in a home health care setting where the same nurse may interact repeatedly with a patient and the patient's family. In addition, if a nurse feels the working conditions will prevent her from meeting the standard of care, it is incumbent on the nurse to decline the position. If Respondent found the environment to be stressful or that it clouded her judgment, she should have refused future assignments to Mom and Dad's home. Staff met its burden of proof to show that Respondent failed in her responsibility to timely initiate CPR and call EMS.

As for the portion of Charge III related to Respondent's communication with EMS, the ALJ finds the evidence lacking. The EMS narrative states that Respondent "was not forthcoming

with info" but does not specify what the difficulty was, or what information was missing. In her testimony, Mom did not address Respondent's interactions with EMS. Respondent herself maintained that she was fully responsive to all requests from EMS.

5. Sanction Analysis

The ALJ finds that under either Code § 301.452(b)(13), pertaining to failure to meet minimum standards of nursing practice, or under Code § 301.452(b)(10), relating to unprofessional or dishonorable conduct, Staff established violations that subjects Respondent to sanction by the Board. With respect to minimum standards, Respondent's conduct violates Board Rule 217.11(1)(B) because she failed to implement measures to promote a safe environment for Patient, and Board Rule 217.11(1)(M) because she did not institute appropriate nursing interventions required to stabilize Patient's condition and/or prevent complications.[27] With respect to unprofessional or dishonorable conduct, Respondent failed to conform to generally accepted nursing standards in the applicable practice setting (Board Rule 217.12(1)(B)) and engaged in conduct that endangered Patient's life, health, and safety (Board Rule 217.12(4)) because she failed to promptly initiate CPR and unreasonably delayed calling 911.[28]

There is overlap between the Code provisions addressing minimum standards and those governing unprofessional conduct. In this case, either provision calls for license revocation. A violation of Code § 301.452(b)(10) that involves failure to comply with a substantive Board rule and results in serious patient harm is a Third Tier offense, and revocation is the sanction recommended in the Matrix. Staff established the aggravating factors of actual harm, severe harm, and patient vulnerability. Respondent did not demonstrate any mitigating factors.

A violation of Code § 301.452(b)(13) with a serious risk of harm or death that is known or should be known is a Third Tier offense, and the recommended sanction is suspension or

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[27] For Charge III, Staff also asserted violations of Board Rule 217.11(1)(A) and (P). The ALJ does not find a separate violation under the more generic scope of Board Rule 217.11(1)(A), which sanctions a failure to know and conform to laws, rules, and regulations. With respect to Board Rule 217.11(1)(P), the evidence did not show that Respondent failed to collaborate with the client, members of the health care team (such as EMS), or the client's significant other(s).

[28] Staff also asserted a violations of Board Rule 217.12(1)(A). However, that rule generally sanctions the inability to perform nursing in conformity with the standards set out in Board Rule 217.11, already addressed separately.

revocation. Staff established actual harm, severe harm, patient vulnerability, and Respondent's prior failure to demonstrate competency during her career (evidenced by her three prior Board Orders) as aggravating factors. Respondent did not prove any mitigating circumstances. The aggravating factors support the harsher sanction of revocation.

For both Code § 301.452(b)(10) and (13), the additional factors the Board should consider from the list in Board Rule 213.33(c) are Respondent's prior disciplinary history and the seriousness of the violation.[29] Respondent's prior Board Orders concerned inappropriate communication with a patient's family (allegedly returning to a client's home after a shift and demanding in a threatening manner for the mother to sign Respondent's flow sheet) in 2008; alleged excessive lateness and sleeping on the job as well as documentation deficiencies in 2009; and alleged failure to obtain medication orders in response to a patient's complaint of extreme pain in 2017.

Accordingly, the ALJ concludes the Board should find Respondent's conduct to be a Third Tier, Sanction Level I offense under both Code § 301.452(b)(10) and (13), and recommends revocation of Respondent's nursing license. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. Theodora N. Anyasinti (Respondent) was issued Licensed Vocational Nurse (LVN) License No. 188481 by the Texas Board of Nursing (Board) on March 21, 2003.

2. Beginning in December 2017, Respondent provided home health nursing services to a pediatric patient (Patient) with developmental delays, seizure disorder, hypothyroidism, and respiratory issues. Patient was dependent on a ventilator to breathe, and had a tracheostomy. Patient's tracheostomy had to be suctioned if it became blocked by phlegm or other secretions, followed by administration of oxygen.

3. If Patient's oxygen saturation fell below 88%, he required immediate administration of oxygen because his low lung reserve meant he could continue to de-saturate very rapidly and could stop breathing.

[29] Board Rule 213.33(c)(6), (14).

4. On October 26, 2018, Respondent began a night shift caring for Patient. Patient's parents (Mom and Dad) are both licensed nurses, and it was their practice for one of them to be home with Patient in addition to Patient's home health nurse.

5. Around 4:00 a.m., Respondent turned off Patient's feeding tube to prepare for a breathing treatment. Respondent began suctioning Patient's tracheostomy.

6. Patient jerked, threw his head back, and began to turn purple, all indications that he was struggling to breathe. Patient's pulse oximeter began flashing, indicating that his pulse rate and oxygen saturation were out of normal range.

7. Respondent should have immediately called 911, attached an ambu (resuscitation) bag to Patient's tracheostomy to begin manual ventilation, and started cardiopulmonary resuscitation (CPR).

8. As the designated healthcare provider, it was Respondent's responsibility to provide calm, objective interventions and care, even if Patient's parents were also healthcare professionals.

9. Respondent froze and did not provide the necessary interventions.

10. At approximately 4:20 a.m., Respondent called for Mom's assistance. When Mom entered the room, Patient's pulse rate was 20 and his oxygen saturation was 40%.

11. Mom initiated CPR and attached the ambu bag, and asked Respondent to call 911 and retrieve the oxygen tank.

12. Respondent brought the oxygen tank into Patient's room but did not properly attach it right away.

13. Five minutes passed before Respondent contacted 911. Respondent held the phone to her ear instead of using the speaker, which would have left her hands free to assist Mom.

14. Emergency medical services (EMS) staff arrived to the home and took over CPR from Mom.

15. EMS transported Patient to the hospital, where he later passed away.

16. Board staff (Staff) investigated Respondent's care of Patient. On May 21, 2019, Staff docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas, for assignment of an Administrative Law Judge (ALJ).

17. On May 22, 2019, Staff sent Respondent a Notice of Hearing and Formal Charges. The notice 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 either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

18. On August 19, 2019, ALJ Pratibha J. Shenoy convened the hearing on the merits. Assistant General Counsel John Vanderford represented Staff. Respondent appeared and represented herself. Respondent acknowledged that she was proceeding as a self-represented litigant after her attorney of record withdrew from representation on August 9, 2019. The record closed on August 19, 2019, at the conclusion of the hearing.

19. While caring for Patient on October 26, 2018, Respondent failed to take proper and timely steps to intervene during Patient's respiratory distress.

20. The evidence did not establish that, between December 2017 and October 2018, Respondent failed to properly assess and/or document respiratory assessments of Patient before and after each suctioning treatment.

21. The evidence did not establish that Respondent violated proper practice or procedure when she performed more than three passes during each suctioning treatment. Other nurses who cared for Patient also exceeded three passes on several occasions.

22. After Patient was transported to the hospital, Respondent attempted to complete her documentation of care but she did not have access to the information or recordkeeping system that she needed to use in order to complete Patient's records.

23. Aggravating factors related to Respondent's conduct include actual harm to a patient, the severity of the harm, and patient vulnerability.

24. Respondent has prior disciplinary history with the Board. She entered into Board Orders in 2007, 2008, and 2017. Respondent completed the terms of all three Board Orders.

25. Respondent did not show that any mitigating standards apply to her conduct.

V. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code (Code) ch. 301.

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

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

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

5. Respondent is subject to sanction because of her failure to implement measures to promote a safe environment for Patient and her failure to institute appropriate nursing interventions required to stabilize Patient's condition and prevent complications. This conduct is subject

to sanction as a failure to meet minimum standards of nursing practice pursuant to Code § 301.452(b)(13) and Board rules at 22 Texas Administrative Code § 217.11(1)(B) and (M).

6. Respondent is subject to sanction because of her failure to conform to generally accepted nursing standards in the applicable practice setting and because her conduct endangered Patient's life, health, and safety. This behavior is subject to sanction as unprofessional conduct pursuant to Code § 301.452(b)(10) and Board rules at 22 Texas Administrative Code § 217.12(1)(B) and (4).

7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the Board's Disciplinary Matrix.

9. The Board may also consider any aggravating and mitigating circumstances set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board revoke Respondent's Licensed Vocational Nurse credential.

SIGNED October 8, 2019.

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS