I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

DOCKET NUMBER 507-20-2560

IN THE MATTER OF PERMANENT CERTIFICATE	**§**	**BEFORE THE STATE OFFICE**
NUMBER 769760, ISSUED TO	**§**	**OF**
BRANDY SOWDER	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: BRANDY SOWDER
P.O. BOX 541
CLIFTON, TX 76634

SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 23, 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 either 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 second tier, sanction level I sanction for her violations of §301.452(b)(12)[1]. The Board further finds that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) and (13)[2]. The Board further agrees with the ALJ that the most appropriate sanction in this matter is a Reprimand with Stipulations for two years[3].

The Respondent's conduct was serious in nature and involved numerous patients[4]. Further, the Respondent's violations were primarily caused by her impaired behavior, which prevented her from practicing nursing with reasonable skill and safety[5]. The Respondent failed to present any mitigating factors and could not explain why narcotics were not administered or why she asked for the keys to the narcotic box[6]. The Respondent also admitted that she had been subsequently terminated from two separate facilities for impairment on duty[7]. Taken together, the Respondent did not present any evidence that she had addressed the cause of her impairment or that she is currently fit to practice independently, particularly in a home health setting with vulnerable patients[8].

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(e)(4), that a Reprimand with Stipulations for two years is the most appropriate sanction in this matter.

The Board finds that the Respondent should complete remedial education courses in nursing jurisprudence and ethics, medication administration, and critical thinking[9]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board further finds that the Respondent's practice should be subject to direct supervision for the duration of the Order. Given the seriousness of the violations and the lack of current fitness to practice demonstrated by the Respondent, the Board agrees with the ALJ that direct supervision is appropriate for the duration of the Order. This supervisory requirement is intended to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The employer notification and quarterly reporting requirements are necessary to ensure the Respondent is complying with the terms of the Order and successfully completes the terms of the

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[1] See pages 13-14 of the PFD.

[2] See adopted Conclusions of Law 6-7 of the PFD, citing violations of §301.452(b)(10) and (13).

[3] See page 16 of the PFD.

[4] See adopted Finding of Fact Number 10 of the PFD

[5] See page 12 of the PFD.

[6] See page 13 of the PFD

[7] See pages 13-14 of the PFD

[8] See page 14 of the PFD

[9] 22 Tex. Admin. Code §213.33(f) requires every order issued by the Board to include participation in a program of education, which at a minimum, shall include a review course in nursing jurisprudence and ethics; see also 22 Tex. Admin. Code §213.33(e)(10).

order. The Board also agrees with the ALJ that the Respondent should be subject to abstention and drug testing for the duration of the Order, since the Respondent exhibited impaired behavior at the instant facility and two subsequent facilities, without any attempt to stop or correct the deficiency[10]. These requirements are authorized by 22 Tex Admin. Code §213.33(e)(4)[11] and are consistent with Board precedent.

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of **REPRIMAND 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. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state.

I. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT shall comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Order.

II. 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.

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[10] See page 14 of the PFD.

[11] 22 Tex. Admin. Code §213.33(e)(4) authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as abstention and drug testing.

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, 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 and video programs will not be approved.

B. 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.

C. A Board-approved course in medication administration with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

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 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 duration [eight (8) 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. **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.

V. DRUG AND ALCOHOL RELATED REQUIREMENTS

A. While under the terms of this Order, RESPONDENT SHALL **abstain from the use of alcohol, nalbuphine, propofol and all controlled substances**, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. In the event that the prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to a pain management and/or chemical dependency evaluation by a Board approved evaluator. The performing evaluator must submit a written report meeting the Board's requirements to the Board's office within thirty (30) days from the Board's request.

B. While working as a nurse under the terms of this Order, RESPONDENT SHALL **submit to random periodic screens for alcohol, nalbuphine, propofol and all controlled substances**. The Board will provide instructions on how to enroll in the Board's drug and alcohol testing program following the entry of this Order and screening will begin when RESPONDENT obtains employment and submits the Notification of Employment form to the Board.

- For the first three (3) month [1st quarter] period RESPONDENT works as a nurse under the terms of this Order, random screens shall be performed at least once per week.
- For the next three (3) month [2nd quarter] period, random screens shall be performed at least twice per month.
- For the next six (6) month period [3rd & 4th quarters], random screens shall be performed at least once per month.
- For the remainder of the probation period, if any, random screens shall be performed at least once every three (3) month quarterly period.

All random screens SHALL BE conducted through urinalysis. Any test result for a period of time in which the RESPONDENT is not working as a nurse under the terms of this Order will not count towards satisfaction of

this requirement. All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation/probation period.

Specimens shall be screened for any or all of the following substances and/or their metabolites:

Amphetamine	Methamphetamine	MDMA
MDA	Alprazolam	Diazepam
Alpha-o-alprazolam	Alpha-Hydroxytriazolam	Clonazepam
Desmethyldiazepam	Lorazepam	Midazolam
Oxazepam	Temazepam	Amobarbital
Butabarbital	Butalbital	Pentobarbital
Phenobarbital	Secobarbital	Codeine
Hydrocodone	Hydromorphone	Methadone
Morphine	Opiates	Oxycodone
Oxymorphone	Propoxyphene	Cannabinoids
Cocaine	Phencyclidine	Ethanol
Heroin	Fentanyl	Tramadol
Meperidine	Carisoprodol	Butorphanol
Nalbuphine	Ketamine	Propofol

Upon enrollment in the Board's drug and alcohol testing program, **RESPONDENT SHALL, on a daily basis, call or login online to the Board's designated drug and alcohol testing vendor to determine whether or not RESPONDENT has been selected to produce a specimen for screening that day** and SHALL, if selected, produce a specimen for screening that same day at an approved testing location and/or comply with any additional instructions from the vendor or Board staff. Further, **a Board representative may appear** at the RESPONDENT'S place of employment at any time during the probation period and require RESPONDENT to produce a specimen for screening.

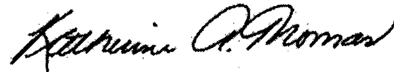
Consequences of Positive or Missed Screens. Any positive result for which RESPONDENT does not have a valid prescription or refusal to submit to a drug or alcohol screen may subject RESPONDENT to further disciplinary action, including TEMPORARY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas. Further, failure to report for a drug screen, excessive dilute specimens, or failure to call in for a drug screen may be considered the same as a positive result or refusal to submit to a drug or alcohol screen.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 23rd day of July, 2020.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-20-2560 (May 7, 2020)

STATE OFFICE OF ADMINISTRATIVE HEARINGS RECEIVED ON 5/7/2020 10:42 AM

ACCEPTED
507-20-2560
05/07/2020 10:47 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Jodi Brown, CLERK

FILED
507-20-2560
5/7/2020 10:42 AM
STATE OFFICE OF
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Jodi Brown, CLERK

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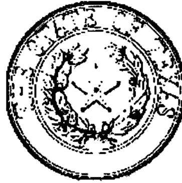

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

May 7, 2020

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

VIA EFILE TEXAS

RE: Docket No. 507-20-2560; Texas Board of Nursing v. Brandy Michelle Sowder

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,

Srinivas Behara
Administrative Law Judge

SB/tt
Enclosures

xc:

Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1-CD of Hearing on the Merits) – **VIA EFILE & INTERAGENCY MAIL**
Brandy Michelle Sowder, P.O. Box 541, Clifton, TX 76634 – **VIA REGULAR MAIL**

P.O. Box 13025 Austin, Texas 78711-3025 | 300 W. 15th Street Austin, Texas 78701
Phone: 512-475-4993
www.soah.texas.gov

SOAH DOCKET NO. 507-20-2560

TEXAS BOARD OF NURSING, **Petitioner**	§ § §	**BEFORE THE STATE OFFICE**
v.	§ §	**OF**
BRANDY MICHELLE SOWDER, **REGISTERED NURSE** **LICENSE NO. 769760,** **Respondent**	§ § § §	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

In six separate formal charges,[1] the staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Brandy Michelle Sowder's (Respondent) Registered Nurse (RN) credential. Staff alleges that between March 5, 2018, and April 16, 2018, Respondent lacked fitness to practice and provided unsafe care to patients as the charge nurse at Lutheran Sunset Ministries (LSM).[2] Respondent does not dispute Staff's allegations but argues for a lesser sanction. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove all of the allegations by a preponderance of the evidence and, for the reasons set forth herein, recommends that the Board issue a Reprimand to Respondent with certain stipulations for two years, including direct supervision, a chemical dependency evaluation, and educational requirements.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

ALJ Srinivas Behara convened the hearing on March 11, 2020, at the State Office of Administrative Hearings (SOAH) facility in Austin, Texas. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and represented herself. The hearing concluded and the record closed the same day. Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

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[1] At the hearing on the merits, Staff withdrew Charge II of VII. In summary, Staff alleges in the remaining charges that Respondent: improperly withdrew a narcotic and created an inaccurate narcotic record; failed to administer medication and treatments to patients; failed to perform pain assessments and reassessment of patients; incorrectly administered approximately 80 scheduled medications; and exhibited impaired behavior on duty.

[2] LSM is a long-term care and rehabilitation facility located in Clifton, Texas.

II. ALLEGATIONS AND APPLICABLE LAW

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, when a nurse: engages in unprofessional conduct (under Code § 301.452(b)(10)); lacks fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public (under Code § 301.452(b)(12)); or fails to meet minimum standards of nursing practice (under Code § 301.452(b)(13)). Staff asserts that Respondent's conduct is grounds for disciplinary action under the three Code provisions above, as well as pursuant to Board Rules 217.11 and 217.12.[3]

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) [All Charges]**: 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) [All Charges]**: Failure to implement measures to promote a safe environment for clients[4] and others;
- **Board Rule 217.11(1)(C) [Charges III, IV, V, and VI]**: Failure to know the rationale for and the effects of medications and treatments and correctly administer the same;
- **Board Rule 217.11(1)(D)(i), (ii), (iv), (v), and (vi) [Charges I and V]**: Failure to accurately and completely report and document: the client's status including signs and symptoms; nursing care rendered; administration of medications and treatments; client response(s); and contacts with other health care team members concerning significant events regarding client's status;
- **Board Rule 217.11(1)(T) [Charge VII]**: Accepting nursing assignments without taking into consideration client safety and accepting nursing assignments that are not commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability; and

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[3] 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 ____." Unless stated otherwise, this Proposal for Decision cites the rules in effect in April 2018 when the alleged conduct occurred.

[4] The terms "client" and "patient" are used interchangeably.

- **Board Rule 217.11(3)(A) [Charges I and III]**: Failing to utilize a systematic approach to provide individualized, goal-directed, nursing care.

Staff also alleges ten violations of Board Rule 217.12, which addresses unprofessional conduct:

- **Board Rule 217.12(1)(A) [All Charges]**: 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;

- **Board Rule 217.12(1)(B) [All Charges]**: Failing to conform to generally accepted nursing standards in applicable practice settings;

- **Board Rule 217.12(1)(C) [Charge I]**: Improper management of client records;

- **Board Rule 217.12(1)(E) [Charge VII]**: Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care;

- **Board Rule 217.12(4) [All Charges]**: Conduct that may endanger a client's life, health, or safety;

- **Board Rule 217.12(5) [Charge VII]**: Demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or as a result of any mental or physical condition;

- **Board Rule 217.12(6)(A) [Charge I]**: Falsifying reports, client documentation, agency records or other documents;

- **Board Rule 217.12(6)(H) [Charge I]:** Providing information which was false, deceptive, or misleading in connection with the practice of nursing;

- **Board Rule 217.12(10)(B) [Charge I]:** Falsification of or making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances; and

- **Board Rule 217.12(11)(B) [Charge I]:** Violating an order of the Board, or carelessly or repetitively violating a state or federal law relating to the practice of vocational, registered or advanced practice nursing, or violating a state or federal narcotics or controlled substance law.[5]

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[5] In its notice of hearing, Staff cited to Board Rule 217.12(11)(B) and generally referenced chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code as the state controlled substances law in effect. However, the Controlled Substances Act contains multiple sections, and Staff did not cite to any specific sections of the statute that Respondent allegedly violated. Furthermore, Staff did not cite to any specific sections of the Controlled Substances Act at the hearing. SOAH's rules state that an allegation contained in a notice of hearing that is not addressed during

When a nurse has violated the Code or Board rules, the Board is required to issue an order imposing a disciplinary sanction.[6] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[7] 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.[8] Staff had the burden of proving its allegations by a preponderance of the evidence.[9]

III. DISCUSSION

A. LSM Background

In 2018, LSM was a 64-bed facility with three different halls, holding 20 residents in each hall. Some residents were totally dependent and some needed more extensive assistance. Respondent was the charge nurse with LSM and regularly worked double shifts on weekends, which typically began with the day shift from 2 p.m. to 10 p.m. and continued through the late shift from 10 p.m. to 6 a.m. LSM's charge nurses were generally responsible for: overseeing nurse aides; administering medications and treatments; performing weekly assessments of patients; and charting for Medicare patients. Brenda Thiele, LSM's Assistant Director of Nursing, was on call 24 hours a day and supervised Respondent. Ms. Thiele was present for the day shifts but was not physically present for night shifts.

At the beginning of each shift, the incoming nurse would transition into her duties by receiving a report from the outgoing nurse before he or she left. Generally, because the late shift was quieter and there was less to report, the outgoing nurse for the late shift was ready to provide

the proceeding may be deemed waived. 1 Tex. Admin. Code §155.425(c). Therefore, the ALJ will not base any findings of violations in this case upon the Controlled Substances Act or Board Rule 217.12(11)(B).

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

[7] Board Rule 213.33(b).

[8] Board Rule 213.33(c).

[9] 1 Tex. Admin. Code § 155.427.

the report to the incoming nurse and leave at 6 a.m. when the shift was over. The outgoing nurse and incoming nurse also performed medication reconciliation together by documenting medications in the medication cart and confirming the numbers matched. LSM nurses were required to report any discrepancy to the Director of Nursing or the Assistant Director of Nursing.

LSM maintained the following process to account for its residents' medications. Each medication was stored in a locked medication cart, and narcotics were separately placed in a locked narcotic box on the medication cart. Within the medication cart, each resident had his or her own drawer for medications and extra medications were located in the medication room, which was a locked room located at each nurse's station. When a nurse was ready to administer a medication, the nurse: found the resident's name on the electronic record; identified the medication; opened the resident's drawer; and withdrew the medicine for administration. The withdrawal and administration of the medication were documented on the electronic Medication Administration Record (MAR). For narcotics, the nurse were also required to document withdrawal and administration by hand-writing the amounts on a Narcotic Count Sheet in a physical binder located on the medication cart.

An LSM nurse was not allowed to "pre-chart" administration of medication. Each nurse was required to accurately note when he or she had administered the medications and had a one-hour window before or after the scheduled medication time to administer the medication. An LSM nurse was not allowed to prepare and administer medications at one time for multiple patients. A second nurse was required to observe and document any wastage of medication.

B. Summary of Evidence and Undisputed Facts

Staff offered nine exhibits, all of which were admitted without objection at the hearing. In support of Charges I and III-VII, Staff called the following witnesses: (1) Ms. Thiele, LSM's Assistant Director of Nursing; (2) Shelby English, a transition nurse for Respondent at LSM; (3) Sandra Van Zandt, LSM's Director of Nursing; (4) Staff's expert witness, Linda Laws; and (5) Respondent. Respondent testified on her own behalf. Respondent did not call any witnesses and offered four exhibits, one of which was admitted.

The undisputed facts for each formal charge, which are based on testimony from Staff's witnesses, Respondent, and the documentary evidence, are set forth below.

1. Charge I

During the late shift on March 5, 2018, Respondent documented in the MAR and progress notes that she withdrew and administered one oxycodone 5/325 mg tablet for Resident ON at 4:11 a.m.[10] Respondent correspondingly noted on the Narcotic Count Sheet that she removed one tablet and that there were fifteen remaining in the blister pack.[11] Before leaving around 6 a.m., Respondent and the transition nurse performed routine medication reconciliation. As required, the transition nurse reported a discrepancy to Ms. Thiele. Ms. Thiele testified that she investigated the report and compared the Narcotic Count Sheet with Resident ON's blister pack. Ms. Thiele made a Xerox copy of Resident ON's blister pack showing that two oxycodone 5/325 mg tablets had been removed,[12] but Respondent did not record wastage of any medication. Ms. Thiele provided background about access to medications and noted that no one other than Respondent had access to Resident ON's medications during Respondent's shift. Ms. Thiele testified that she brought the discrepancy to Respondent's attention and counseled Respondent.

At the hearing, Respondent did not dispute that the blister pack showed a discrepancy, but she did not recall this incident. Respondent testified that she received counseling from LSM on at least one occasion relating to her work performance, but she was unsure if she received counseling for this incident.

2. Charge III

Respondent was the charge nurse for the 2 p.m. to 10 p.m. shift on April 8, 2018.[13] A physician's order indicated that Resident EV was scheduled to receive a B12 injection during Respondent's shift. Respondent indicated in the Treatment Administration Record that she

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[10] Staff Ex. 6 at 6-8.

[11] Blister packs contain designated sealed compartments, or spaces for medicines to be taken at particular times of the day.

[12] Staff Ex. 6 at 6-8.

[13] Staff Ex. 6 at 49.

administered the B12 injection. However, the next day Resident EV's B12 vial was found in the resident's drawer in the medication cart. Ms. Thiele testified that she initiated an investigation and confirmed with Resident EV that the resident did not receive the injection. Respondent also verbally confirmed to Ms. Thiele that she did not give the injection to Resident EV. Respondent testified that her failure to administer the injection was a "poor job" on her part. Respondent specifically recalled that Ms. Thiele counseled Respondent for failing to administer the injection.[14]

3. Charges IV - VII

Staff's Charges IV through VII involve the late shift on April 15-16, 2018.[15] Three of the charges relate to Respondent's failure to administer medications and treatments to patients:

- Respondent testified that she failed to change Foley catheters for Residents JC and DJ, as scheduled and ordered by a physician.[16]
- Respondent admitted that for Residents FH, PR, and HH, she either failed to administer PRN (as needed) pain medications, as ordered by a physician, or failed to assess each resident's pain for effectiveness after administration.[17]
- Respondent admitted that she incorrectly administered approximately 80 scheduled medications when she documented administration times that were between one to eight hours after the ordered times for the medication.

Staff alleges in Charge VII that Respondent exhibited impaired behavior at the end of her late shift. Ms. English, the transition charge nurse for the 6 a.m. to 2 p.m. shift, testified that she approached Respondent at the nurse's station desk to receive a transition report and to perform routine medication reconciliation. Ms. English observed that Respondent's work area was disorganized and Respondent had multiple medications for multiple residents spread out on one tray. Ms. English observed that Respondent's eyes were barely open, her speech was slurred, and she was incoherent. Ms. English further testified that Respondent was confused and did not recognize Ms. English, although Ms. English had transitioned for Respondent on several prior

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[14] Staff Ex. 6 at 56.

[15] Staff Ex. 7 at 1.

[16] *See also* Staff Ex. 6 at 29.

[17] Staff Ex. 6 at 15-17.

shifts. According to Ms. English, Respondent then asked Ms. English for the key to the narcotic box so that she could withdraw two hydrocodone pills from the narcotic box. Ms. English was unclear why the pills withdrawn and there was no record of administration. Ms. English noted that Respondent did not perform any Medicaid charting and did not replenish the medication cart.

Ms. English testified that she later consulted with Resident FH during her rounds who stated she was in pain and had asked Respondent for PRN but had not received the medication. Respondent, however, had indicated in the MAR that the medication had been administered. Because Respondent was unresponsive, Ms. English attempted to check the MAR for the remainder of the residents and begin preparing and administering medications but numerous medication entries were displayed in red, which indicated all medications were late.[18]

Ms. English and Ms. Thiele described that Respondent stayed at least an hour over her shift and for much of the time was asleep in front of the computer at the nurse's station. Ms. Van Zandt testified that when she was made aware of Respondent's behavior, she approached Respondent, but Respondent was extremely slow to respond and sluggish. Ms. Van Zandt stated that she had to slam on the desk to wake Respondent.

C. Respondent's Testimony

Respondent testified that she has about nine years of experience as an RN. She recalled being extremely busy on the night shift of April 15-16, 2018, and she "got behind" on medication administration. Respondent also stated that, at the time, she did not realize she was in a bad state because she was taking several medications for various ailments, including multiple sclerosis, an infection in her mouth, and shingles. Respondent testified that there were only two nurses on the late shift, and she had to attend to 60 residents with only two nurse aides on duty. Respondent acknowledged she could have called Ms. Thiele or others for help but she stated she did not want bother anyone in middle of night.

[18] Staff Ex. 6 at 64-111.

Respondent testified that after LSM terminated her employment for her conduct and impairment on April 16, 2018, she "took a break" for over a year. On cross-examination, however, Respondent admitted that after her termination from LSM, she did not take a break and instead took positions at two different long-term care facilities. Respondent admitted that she was in each position only for a few days before she was terminated for "the same thing" as LSM, which included her falling asleep on duty and showing slurred speech, confusion, and grogginess. According to Respondent, she sought a position that did not have as much pressure with as many patients and was hired by Angels of Care Pediatric Home Health, a home health care agency where she primarily takes care of one patient. Respondent claimed that she has adjusted well to the position. Respondent stated that she intended to obtain a letter of recommendation from Angles of Care but did not get a response from her supervisor. Finally, Respondent testified that she made her own decision to take herself off all medications and that she no longer has an issue with the side effects of her medications.

D. Ms. Laws' Testimony

Ms. Laws has been a nurse for 42 years and has been licensed to practice in Texas, Virginia, and Indiana. She has worked for the Board since 2011 and is currently a Practice Consultant for the Board. Her duties include answering questions regarding the Board's rules and their application to nursing practice and providing educational workshops to nurses. Ms. Laws is familiar with the Code and the Board's rules and uses them in her day-to-day work. Her testimony focused on the appropriate sanction the Board may fashion if Staff's charges are proven true:

- Charge I. Ms. Laws testified that all nurses are required to know state, federal, and other applicable agency rules, including the Texas State Board of Pharmacy rules, which require a nurse to understand the accurate counting of narcotics. Ms. Laws further testified that Respondent's conduct as alleged in Charge I violated the Board's documentation rules based on her failure to accurately document administration of medication. Ms. Laws noted that Respondent's conduct posed a risk of harm that could have caused delay in treatment or administration of important medication.

- Charge III. Ms. Laws stated that a B12 injection is typically ordered for a patient's specific deficiency, and it is generally administered once a month. Ms. Laws concluded that Respondent's conduct as alleged in Charge III indicated a lack of fitness to practice. Ms. Laws noted that if a patient does not get a B12 injection at

the time as ordered, it could harm the patient by exposing weaknesses in the immune system and result in heart palpitations and respiratory distress.

- Charge IV. Ms. Laws further noted that any time a catheter is placed into a body, it provides a direct route for bacteria and makes the patient susceptible to infection. Ms. Laws testified that the national standard of care requires a nurse change a catheter once a month. Respondent's conduct unnecessarily exposed the residents to a risk of urinary tract infection and sepsis, which has a high risk of death.

- Charge V. Ms. Laws referenced the nursing minimum standards that require a nurse to assess a patient after giving pain medications and if still in pain, to determine why the pain medications did not help or if effective.

- Charge VI. Ms. Laws testified that the national standard is for a nurse to administer medications within a one-hour window before or after the scheduled time for administration. Ms. Laws testified that late medication administration disrupts subsequent medication administration times. Ms. Laws noted that she and LSM did not determine that Respondent's conduct resulted in any specific harm to any patients. Ms. Laws noted that if a nurse gets behind schedule, the nurse should ask or call for help rather than risk patient safety.

- Charge VII. Ms. Laws pointed out that Respondent's condition could have affected her ability to recognize subtle signs, symptoms, or changes in a resident's condition. Ms. Laws further noted that Respondent's impairment 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.

Ms. Laws testified that Respondent's alleged conduct involved multiple incidents with a risk of patient harm. Based on the lack of proof of any mitigating factors and the existence of several aggravating circumstances, including the number of events, impairment at the time of the incident, and patient vulnerability, Ms. Laws stated that each violation would be considered a Second Tier offense, Sanction Level 1 in terms of the Board's Matrix. Finally, Ms. Laws testified that based on the appropriate sanction for Respondent would include a Reprimand and require her to: complete remedial education in critical thinking and medication use/administration; practice under direct supervision for two years; and abstain from unauthorized use of drugs and alcohol to be verified by random drug testing for the duration of the Board's order

E. Analysis

1. Violations

Staff met its burden of proof on all violations by presenting uncontroverted evidence to support the following:

Charge I – Respondent documented on the Narcotic Count Sheet for Resident ON that she only removed one oxycodone 5/325mg tablet, but the patient's blister pack showed that two tablets had been removed, and Respondent did not document wastage. Respondent's actions were unprofessional and violated the minimum standards of nursing practice, Code §§ 301.452(b)(10) and (13), as well as Board Rules 217.11(1)(A), (B), (D), and (3)(A), and 217.12(1)(A), (B), (C), (4), (6)(A), (H), and (10)(B).

Charge III – Respondent failed to administer a B12 injection to Resident EV, as scheduled and ordered by a physician. Respondent's actions were unprofessional and violated the minimum standards of nursing practice, Code §§ 301.452(b)(10) and (13), as well as Board Rules 217.11(1)(A), (B), (C), and (3), and 217.12(1)(A), (B), and (4).

Charge IV – Respondent failed to change the Foley catheters for Residents JC and DJ, as scheduled and ordered by a physician. Respondent's actions were unprofessional and violated the minimum standards of nursing practice, Code §§ 301.452(b)(10) and (13), as well as Board Rules 217.11(1)(A), (B), (C), and (3)(A), and 217.12(1)(A), (B), and (4).

Charge V – Respondent failed to accurately document administration and failed to administer pain medications for Residents FH, PR, and HH, as ordered. Respondent's actions were unprofessional and violated the minimum standards of nursing practice, Code §§ 301.452(b)(10) and (13), as well as Board Rules 217.11(1)(A), (B), (C), and (D), and 217.12(1)(A), (B), and (4).

Charge VI – Respondent incorrectly administered at least 80 scheduled medications to 18 residents by documenting administration times that were between one and eight hours after the ordered times for the medications. Respondent's actions were unprofessional and violated the

minimum standards of nursing practice, Code §§ 301.452(b)(10) and (13), as well as Board Rules 217.11(1)(A), (B), and (C), and 217.12(1)(A), (B), and (4).

Charge VII – Respondent lacked fitness to practice professional nursing in that she exhibited impaired behavior on April 16, 2018, including but not limited to: having slow, slurred speech; acting groggy and confused; being unable to keep her eyes open; having unsteady gait and sluggish movements; being unable to recognize her co-workers; and sitting at the computer with her eyes closed. Respondent's actions exhibited a lack of fitness to practice nursing, were unprofessional, and violated the minimum standards of nursing practice, Code §§ 301.452(b)(10), (12), and (13), as well as Board Rules 217.11(1)(A), (B), and (T), and 217.12(1)(A), (B), (E), (4), and (5).

2. Sanctions

Staff sufficiently proved a number of violations by Respondent, thereby warranting the imposition of sanctions against her. Pursuant to Board Rule § 213.33(a), the Board and SOAH are required to utilize the Matrix in all disciplinary matters to determine the appropriate sanction. For violations of Code § 301.452(b)(10), (b)(12), and (b)(13), the Matrix lists several possible sanction tiers and levels. Although Staff proved violations of three Code provisions, the credible evidence demonstrated that the primary cause of Respondent's violations was her impaired behavior, which prevented her from practicing nursing with reasonable skill and safety. Accordingly, her conduct is most appropriately analyzed as lack of fitness to practice under Code § 301.452(b)(12).[19]

Conduct violating Code § 301.452(b)(12) is classified by the Matrix as a first tier violation if it involves "[a]ny mental health condition, diminished capacity, or physical health condition that may impair an individual's behavior, judgment, or ability to function in school or work."[20] A second tier violation involves a "[l]ack of fitness based on any mental health condition, diminished capacity, or physical health condition with potential harm or adverse patient effects or other serious

[19] *See* Board Rule 213.29.

[20] Board Rule 213.33(b).

practice violations."[21] The term "lack of fitness" includes observed behavior such as slurred speech, unsteady gait, sleeping on duty, and inability to focus or answer questions appropriately.[22]

Staff carried its burden to prove that Respondent was impaired on the morning of April 16, 2018, and Respondent did not argue to the contrary. Here, there was no credible evidence that Respondent's impairment related to a physical condition or diagnosis of some psychotic disorder, and her behavior exhibited potentially significant harm to vulnerable patients and other serious practice violations. Regardless of any medications she may have been taking on the day of the incident, Respondent was on duty at LSM, and it was incumbent on her to ensure she was not impaired, or to recognize that she could not perform her duties and make appropriate arrangements. By providing inaccurate patient information for important medication and treatment administration, Respondent's behavior also placed her co-workers at risk. Therefore, Respondent's lack of fitness is appropriately classified as a second tier violation.

While the ALJ may recommend a sanction, the Board remains the ultimate arbiter of the disciplinary action taken in this case.[23] Within each tier, the Matrix sets forth sanction levels I and II that are determined by reference to aggravating and mitigating factors. In addition, Board Rule 213.33(c) provides a list of factors that the Board and SOAH shall consider in conjunction with the Matrix.

One relevant factor on the list is evidence of any mitigating factors. Respondent did not present evidence of any mitigating circumstances, such as successful response to treatment, and she did not provide any psychological or chemical dependency evaluations. Moreover, Respondent's testimony was difficult to credit. Respondent did not present any credible evidence to support her claim that she suffered from several ailments. Respondent could not explain why narcotics were not administered or why she asked Ms. English for the keys to the narcotic box. Respondent also demonstrated a lack of trustworthiness when she testified about her work history after her termination with LSM. In addition, on cross-examination, Respondent admitted she was

[21] Board Rule 213.33(b).

[22] Board Rule 213.33(b).

[23] *See* Code § 301.459(a-1). ("The board has the sole authority and discretion to determine the appropriate action or sanction.").

terminated because of her impairment on duty at two similar facilities. Respondent's subsequent impairment indicates she did not recognize or attempt to stop or correct her behavior. There was no evidence that Respondent has properly addressed the cause of her impaired behavior, and the greater weight of the evidence demonstrated that Respondent is not safe to practice independently, particularly in a home health setting with vulnerable populations.

Given Respondent's conduct in the relevant time period, significant concerns exist about Respondent's present fitness to practice as an RN. Because the primary objective of sanctions is to ensure the protection of the public, the appropriate sanction is level I, and the ALJ adopts Staff's recommendations as set forth below in Section VI of this proposal for decision. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. Brandy Michelle Sowers (Respondent) was issued Registered Nurse (RN) License No. 769760 by the Texas Board of Nursing (Board).

2. Between March 5, 2018, and April 16, 2018, Respondent was the charge nurse at Lutheran Sunset Ministries (LSM) in Clifton, Texas.

3. Respondent had nine years of nursing practice experience as an RN.

4. On March 5, 2018, Respondent documented in the Medical Administration Record (MAR) and Narcotic Count Sheet for Resident ON that she only removed one oxycodone 5/325mg tablet, but two tablets had been removed.

5. On April 8, 2018, Respondent indicated in the Treatment Administration Record that she administered a B12 injection for Resident EV when she had not administered the B12 injection, as scheduled and ordered by a physician.

6. On April 15, 2018, Respondent failed to change the Foley catheters for Residents JC and DJ, as scheduled during her shift and ordered by a physician.

7. On April 15, 2018, for Residents FH, PR, and HH, Respondent either failed to administer PRN (as needed) pain medications, as ordered by a physician, or failed to assess each resident's pain for effectiveness after administration

8. From April 15, 2018, through April 16, 2018, Respondent incorrectly administered approximately 80 scheduled medications to LSM patients in that Respondent documented administration times that were one to eight hours after the ordered times for the medications.

9. On April 16, 2018, Respondent exhibited impaired behavior on duty, including: having slow, slurred speech; acting groggy and confused; being unable to keep her eyes open; having unsteady gait and sluggish movements; being unable to recognize her co-workers; and sitting at the nurse station computer with her eyes closed.

10. Respondent's conduct was serious and involved vulnerable patients.

11. Respondent did not stop or correct the behavior she exhibited at LSM.

12. After her termination from LSM, Respondent's employment was also terminated from two long-term care facilities for exhibiting impaired behavior.

13. On February 10, 2020, Staff filed formal charges against Respondent concerning her conduct at LSM and docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas, for assignment of an Administrative Law Judge (ALJ).

14. On February 27, 2020, Staff sent Respondent an Amended 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.

15. On March 11, 2020, ALJ Srinivas Behara convened the hearing on the merits. Deputy General Counsel Jena Abel represented Staff. Respondent appeared and represented herself. The record closed the same day.

16. At the hearing, Respondent was not honest about her employment history subsequent to LSM.

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's conduct at LSM is subject to sanction as she failed to exhibit a current fitness to practice nursing pursuant to Code § 301.452(b)(12) and Board rule found at 22 Texas Administrative Code § 213.29.

6. Respondent's conduct at LSM is subject to sanction as a failure to meet minimum standards of nursing practice pursuant to Code § 301.452(b)(13) and Board rules found at 22 Texas Administrative Code § 217.11(1)(A), (B), (C), (D), (T), and (3)(A).

7. Respondent's conduct at LSM is subject to sanction as unprofessional conduct that was likely to deceive, defraud, or injure a patient or the public pursuant to Code § 301.452(b)(10) and Board rules found at 22 Texas Administrative Code § 217.12(1)(A), (B), (C), (E), (4), (5), (6)(A), (H), (10)(B), and (11)(B).

V.

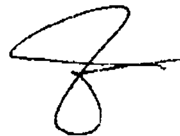
8. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

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

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board sanction Respondent by issuing a Reprimand and require her to: complete remedial education in critical thinking and medication use/administration; practice under direct supervision for two years; and abstain from unauthorized use of drugs and alcohol to be verified by random drug testing for the duration of the Board's order.

SIGNED May 7, 2020.



SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS