DOCKET NUMBER 507-20-2750

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 938895, ISSUED TO CHRISTIANAH OMOLARA BELLO	§	BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

OPINION AND ORDER OF THE BOARD

TO: CHRISTIANAH OMOLARA BELLO
C/O MARC M. MEYER, ATTORNEY
525 WOODLAND SQUARE BLVD.
SUITE 250
CONROE, TX 77384

SARAH STARNES
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 22-23, 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 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 ALJ found that the Respondent's conduct warrants a second tier, sanction level II sanction for her violations of §301.452(b)(10) and (13)[1]. In pertinent part, either a suspension, enforced or probated, or licensure revocation is authorized under a second tier, sanction level II sanction[2]. The Board agrees with the ALJ that an Enforced Suspension, followed by a two-year probationary period, is the most appropriate sanction in this case.

There are several aggravating factors present in this case. First, Respondent's conduct placed a vulnerable patient at risk of harm, and actual harm occurred[3]. Respondent accepted an assignment despite lacking sufficient orientation and training, which could reasonably be expected to result in unsafe or ineffective care[4]. Further, Respondent did not call for help when she realized her orientation was inadequate, creating an unsafe environment for the patient[5]. Respondent failed to follow the patient's plan of care and inappropriately administered treatments to the patient[6]. Respondent's failure to accurately assess the patient's breathing status and respond to the alarming oximeter endangered the patient's life[7]. Further, multiple violations were present in this case[8].

The Board recognizes that the ALJ also identified mitigating factors in this case. The Respondent continued working as a nurse after this event in the home health setting[9]. Respondent has no prior disciplinary history with the Board, and there is no evidence of other negative practice history after this event[10]. Further, Respondent's inexperience and lack of training contributed to the event[11].

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)(6), that licensure suspension is the most appropriate sanction in this matter. Further, the Board agrees with the ALJ that the suspension should be enforced until Respondent completes the specified remedial education courses, and then should be probated for a period of two years, subject to the specified probationary stipulations in this Order.

Consistent with the ALJ's recommendation that the Respondent's license should be suspended until she complete remedial education courses, the Board finds that the

---

[1] See pages 20 and 23 of the PFD.

[2] See the Board's Disciplinary Matrix, located at 22 Tex. Admin. Code §213.33(b).

[3] See adopted Findings of Fact Numbers 63-64 of the PFD.

[4] See adopted Findings of Fact Numbers 16-17 of the PFD.

[5] See adopted Findings of Fact Numbers 18-19 of the PFD.

[6] See adopted Findings of Fact Numbers 33 and 36 of the PFD.

[7] See adopted Finding of Fact Number 55 of the PFD.

[8] See adopted Finding of Fact Number 62 of the PFD.

[9] See adopted Finding of Fact Number 59 of the PFD.

[10] See adopted Finding of Fact Number 68 of the PFD.

[11] See adopted Findings of Fact Numbers 65-66 of the PFD.

Respondent should be required to complete a nursing jurisprudence and ethics, physical assessment, documentation, and critical thinking course[12]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas; to reinforce the Respondent's knowledge of basic nursing skills, like physical assessment and nursing documentation; and to prevent future violations from occurring. Once the Respondent completes these courses, the Board finds that the Respondent's license should be placed in probated status for a period of two years. During that period of time, the Board finds that the Respondent's practice should be directly supervised for the first year of the Order and indirectly supervised for the second year of the Order. The Board further finds it appropriate to prohibit the Respondent from working in independent practice settings, like home health or hospice, and from being employed temporarily by agencies. These supervisory requirements are intended to prevent additional violations from occurring and to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. Like the ALJ, the Board agrees that these stipulations are reasonably targeted to address the violations and ensure the Respondent is safe to practice independently again[13]. Finally, the Respondent will be required to inform her employers of this Order and to submit quarterly employer reports to the Board so the Board can monitor the Respondent's progress and completion of the Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(6)[14] and are supported by the evidentiary record in this case.

IT IS THEREFORE ORDERED that Registered Nurse License Number 938895, previously issued to CHRISTIANAH OMOLARA BELLO, to practice nursing in the State of Texas is hereby **SUSPENDED** and said suspension is **ENFORCED** until RESPONDENT:

A. **Successfully completes a Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study courses and video programs will not be approved.

---

[12] 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 pages 22-23 of the PFD.

[13] See page 23 of the PFD.

[14] 22 Tex. Admin. Code §213.33(e)(6), which 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 limitations on nursing activities/practice settings.

B. **Successfully completes a** Board-approved course in physical assessment 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 physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. 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.

C. **Successfully completes a Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

D. **Successfully completes 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.

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.*

IT IS FURTHER ORDERED, upon verification of successful completion of the above requirement(s), the Suspension will be **STAYED**, and RESPONDENT will be placed on **PROBATION**, in accordance with the terms of this Order, for a minimum of two (2) years AND until RESPONDENT fulfills the additional requirements of this Order.

- RESPONDENT SHALL pay all re-registration fees, if applicable, and RESPONDENT'S licensure status in the State of Texas will be updated to reflect the applicable conditions outlined herein.

- This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

- This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

- As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

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. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

III. FURTHER COMPLAINTS

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

IV. 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 22nd day of October, 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. 507-20-2750 (August 14, 2020)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

August 14, 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. 507-20-2750; Texas Board of Nursing v Christianah Bello, RN.

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,

Sarah Starnes

Sarah Starnes
Administrative Law Judge

SS/db
Enclosures

xc: Helen Kelley, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS**

Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS**

Elizabeth Tschudi, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD of Hearing on the Merits) – **SENT INTERAGENCY)**

Marc M. Meyer, Marc Meyer Law Firm, 525 Woodland Square Blvd, Suite 250, Conroe, TX 77384 – **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-20-2750

TEXAS BOARD OF NURSING, Petitioner	§ §	BEFORE THE STATE OFFICE
v.	§	OF
CHRISTIANAH BELLO, RN Respondent	§ §	ADMINISTRATIVE HEARINGS

TABLE OF CONTENTS

SOAH DOCKET NO. 507-20-2750

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
CHRISTIANAH BELLO, RN Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to suspend the Registered Nurse (RN) credential held by Christianah Bello (Respondent) based on alleged deficiencies in her care of a pediatric patient (Patient), who died while Respondent was providing her in-home care. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove most of the allegations in its three charges. The ALJ recommends that the Board suspend Respondent's license for two years, with stipulations and with educational requirements that must be met before the suspension can be probated.

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. On June 23, 2020, ALJ Sarah Starnes convened a telephonic hearing before the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel Helen Kelley represented Staff. Respondent was represented by attorney Marc Meyer. The record closed on August 3, 2020, after the parties filed written closing arguments.

II. APPLICABLE LAW

The Texas Nursing Practice Act (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

is grounds for disciplinary action under both Code provisions, as well as pursuant to Board Rules 217.11 and 217.12.[1]

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

- **Board Rule 217.11(1)(A)**: Failure to know and conform to the Act 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, administration of medications and treatments, and client responses;
- **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;
- **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;
- **Board Rule 217.11(1)(T)**: Failure to accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and abilities; and
- **Board Rule 217.11(3)(A)**: Failure to utilize a systematic approach to providing individualized, goal-directed nursing care, including by performing comprehensive nursing assessments regarding the client's health status, implementing nursing care, and evaluating the client's responses to nursing intervention.

[1] 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 ____."

Staff also alleges five types of violations under Board Rule 217.12, which addresses unprofessional conduct:[2]

- **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;

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

- **Board Rule 217.12(1)(E)**: 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; 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.[3] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[4] 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.[5]

Staff has the burden of proving its allegations by a preponderance of the evidence.[6]

---

[2] Board Rule 217.12 was amended effective October 17, 2019, after the events at issue in this case. The amendments did not substantively change the provisions relied on by Staff, so the current version of the rule is cited in the Proposal for Decision.

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

[4] Board Rule 213.33(b).

[5] Board Rule 213.33(c).

[6] 1 Tex. Admin. Code § 155.427.

III. EVIDENCE

Staff offered eleven exhibits that were admitted without objection,[7] and presented testimony from Respondent. Staff also offered the expert testimony of Heather Franz, APRN, who is a nursing practice consultant to the Board. Respondent did not offer exhibits or any witness testimony other than her own. Respondent did not contest many of the facts alleged in Staff's charges, but contended that the circumstances support a lesser sanction than the two-year suspension sought by Staff.

A. Background[8]

After receiving her RN license in February 2018,[9] Respondent began working as a private-duty nurse for Thrive Skilled Pediatric Care (Thrive) in Conroe, Texas. In April 2018, she moved to Thrive's Houston location. On August 18, 2018, Respondent was assigned to an overnight shift providing in-home care for an eight-year-old patient (the Patient) who had been paralyzed in a vegetative state since an acute brain injury in infancy. The Patient could not move or breathe on her own. She was dependent on a ventilator and had a tracheostomy (trach) where the ventilator connected to her windpipe.

The Patient had received private nursing services from Thrive since at least January 2018,[10] but the overnight shift from August 18-19, 2018 was the first time Respondent had been assigned to work with the Patient. Respondent's shift was scheduled to begin at 7:00 p.m., but when she arrived at the Patient's home shortly before the shift started, Respondent was told she had been

---

[7] Staff Exs. 1-11.

[8] This Background section is derived from Staff's exhibits and Respondent's testimony. Unless otherwise indicated, the background facts were undisputed.

[9] Staff Ex. 1.

[10] Staff Ex. 5 at 27.

expected to arrive two hours earlier for orientation.[11] Typically, according to Respondent, she would receive at least several hours of orientation on a new patient and would sometimes work a full shift alongside another nurse before working independently with such a fragile and medically-complex patient. Here, however, the licensed vocational nurse (LVN) who had worked the day shift gave Respondent a short, approximately twenty-minute orientation before leaving Respondent alone to care for the Patient.

The Patient's treatment plan included orders for her skilled nurse to consistently assess the Patient's respiratory status; suction her trach at signs of congestion, increased secretions, or respiratory distress; clean and maintain the trach; and take emergency measures if the trach became obstructed or dislodged or if the patient was not breathing clearly. The plan also stated that the Patient should be continuously monitored by pulse oximetry, and directed the skilled nurse to perform intrapulmonary percussive ventilation (IPV) treatments three times a day, as needed and as tolerated by the Patient. The treatment plan stated that nebulizer treatments could be given if the Patient did not tolerate the IPV treatments.[12] The treatment plan also directed the skilled nurse to "check all equipment/settings at the beginning and end of the shift and notify DME for any malfunctioning equipment."[13] In the event of an emergency with the trach, the treatment plan described measures the skilled nurse should take, including changing the trach tube or, if that failed, ventilating with a mask and bag affixed to the Patient's nose. The plan also directed the skilled nurse to call 911 immediately if there were a trach emergency.[14]

IPV is a therapy used to maintain clear airways on ventilated patients. The IPV device is connected to the patient's ventilator through a tube and delivers percussive bursts of air and

---

[11] The parties dispute whether Respondent knew beforehand that she had been expected at 5:00 p.m. In an interview with her supervisors following the incident, Respondent purportedly admitted that she forgot to set an alarm that would have wakened her in time to arrive for orientation at 5:00 p.m. Staff Ex. 7 at 2. In her testimony at the hearing, Respondent denied this and testified that a 5:00 orientation had been suggested, but she never agreed to it or confirmed, and as far as she knew she was supposed to arrive for her shift at 7:00 pm.

[12] Staff Ex. 5 at 6-8, 33.

[13] Staff Ex. 5 at 14. Though not specified by the evidence in this case, "DME" is apparently an acronym for Durable Medical Equipment.

[14] Staff Ex. 5 at 8.

medications into the lungs. During her short orientation with the LVN at the start of her shift, Respondent noticed that the Patient's IPV device was held together by tape. The LVN told her that the Patient's father had taped it together and that was how they normally used the device. Respondent took that to mean that Thrive was aware of and accepted the equipment's condition, so she did not call Thrive to report a defective or malfunctioning IPV device. Respondent's nursing notes from that night indicated that she had checked all of the Patient's equipment at the beginning of her shift to ensure there was no malfunctioning equipment.[15]

Respondent's nursing notes reflect that she assessed the Patient at the start of her shift, and the Patient's vital signs remained stable for the next several hours as Respondent administered medications, repositioned the patient, changed her diaper, and administered a tube-feeding.[16] Around 11:00 p.m., Respondent noted that the Patient's vital signs were still within normal limits, but the Patient was having a lot of secretions despite Respondent having suctioned her mouth and nose. Shortly after midnight, Respondent administered an IPV treatment with albuterol, a breathing treatment. Her notes state that the "IPV was not functioning correctly and was taped, [and] there was yellow rubber at the top."[17] About three minutes after starting the IPV treatment, the Patient's heart rate dropped to 64 beats per minute (it had been 102 at the start of the shift), and her oxygen saturation level fell from 98% to 72%.[18] In response to this desaturation, Respondent administered supplemental oxygen and the Patient's heart rate and pulse oxygen returned to a normal range. Then, rather than switching to the Patient's nebulizer to administer medication, Respondent next tried to administer budesonide, an alternative breathing treatment, with the IPV machine.[19] As the budesonide was administered, the Patient's heart rate and pulse oxygen fell again (to 74 beats per minute and 60%), which again prompted Respondent to

---

[15] Staff Ex. 5 at 61.

[16] Staff Ex. 5 at 48.

[17] Staff Ex. 5 at 48.

[18] Staff Ex. 5 at 45, 48.

[19] Staff Ex. 5 at 48. In her closing brief, Respondent suggested that the budesonide was administered by nebulizer rather than IPV machine. As discussed below, in § IV.B addressing Charge II, the preponderance of the evidence shows that both medications were administered by IPV.

administer oxygen to raise them. Respondent then disconnected the IPV machine.[20] Respondent's nursing notes from 12:45 a.m. indicate the Patient "did not tolerate" the IPV treatment.[21]

Respondent said she remained next to the Patient for 2-3 minutes after reconnecting the ventilator, and that the Patient appeared fine after the two desaturation events. Then she left the Patient's bedside to clean the IPV equipment in the adjacent bathroom. Within about five minutes, the patient's pulse oximeter began alarming, indicating that no pulse was registering on the device.[22] Respondent returned to the Patient and saw secretions coming from the Patient's mouth and nose, and tried to suction them. She moved the pulse oximeter sensor from the Patient's left leg to her right leg, and then to both thumbs, but could not get a reading on any of the Patient's extremities. Respondent then tried to check the Patient's pulse manually and thought she detected a weak pulse on her wrist, even though nothing was registering on the pulse oximeter.

Respondent went upstairs to get help from the Patient's parents because she suspected the pulse oximeter's sensor might be defective and she hoped the parents could find another one.[23] Both of the Patient's parents later told investigators that Respondent did not appear panicked when she awoke them and reported only that "the machine" was not working.[24] The Patient's father ran down the stairs, with Respondent close behind. The father arrived at the Patient's bedside first and told Respondent to get the Patient's mother, and he called an ambulance. Apparently seeing that the Patient was turning blue, the father said aloud that the Patient's trach tube had become dislodged. While they waited for the ambulance to arrive, the father tried to change the Patient's trach tube using spare equipment by the Patient's bedside.[25] The Patient's mother found a

---

[20] Staff Ex. 5 at 48.

[21] Staff Ex. 5 at 45, 54.

[22] Staff Ex. 7 at 17.

[23] Staff Ex. 7 at 17.

[24] Staff Ex. 7 at 15-16.

[25] It is not clear from the evidence whether the Patient's trach tube was, in fact, dislodged, or whether something else caused the Patient to stop breathing. Staff has not alleged that Respondent dislodged the trach tube, and the father's efforts to replace the tube did not restore the Patient's pulse or oxygen levels. Mr. Franz testified that there was no autopsy report that determined the patient's cause of death.

replacement sensor for the pulse oximeter and confirmed it was working by testing it on herself, but she still could not get a reading from the Patient. In retrospect, Respondent agreed that the Patient was already dead at that point. Both parents told investigators that they felt Respondent had panicked once it was clear the Patient was not breathing, and she had not been able to help in the emergency.[26] When the ambulance arrived, the EMTs tried to use their own equipment to detect a pulse but found none. The mother told them that the Patient had a "do not resuscitate" (DNR) order, and she turned off the Patient's ventilator.[27]

The same night, police and Child Protective Services were called to investigate the Patient's death, and Respondent and the parents were all interviewed for several hours. Thrive called Respondent after the police interviews, early in the morning on August 19, 2018, and told her to complete her nurse's notes from the shift. The Patient's death was investigated by Thrive and other agencies, including the Texas Department of Family and Protective Services and Texas Health and Human Services Commission (HHSC), which both regulate aspects of home health care. The Patient's parents both told investigators that they did not think Respondent had been properly trained to care for the Patient.[28] Thrive was cited for numerous violations, including inadequately training Respondent when she was hired and failing to ensure that Respondent received "adequate in-home orientation/training prior to encountering new equipment and technology or unfamiliar care situations."[29]

B. Respondent's Testimony

Respondent had only been a licensed RN for about six months when she was assigned to work with the Patient, and she admits that she was unprepared to care to for such a complex and fragile patient. She completed a competency evaluation when she was initially hired by Thrive, and it reflects that Respondent asked her employer for "additional training on trach patient prior

---

[26] Staff Ex. 7 at 15-16.

[27] Staff Ex. 7 at 17.

[28] Staff Ex. 7 at 15-16.

[29] Staff Ex. 5 at 48-49, 52.

to working independently."[30] She said she received only a general orientation when she was hired by Thrive's Conroe office, and did not receive any additional orientation or training when she moved to the Houston location. Before her shift with the Patient, Respondent had previously cared for several other patients on ventilators, and she had been generally trained on how to replace a trach tube, but she had never performed a replacement on one of her patients or been faced with a trach emergency.

According to Respondent, she should have received at least twelve hours of orientation on how to care for the Patient before working alone with her. That was how Thrive trained her for a similar case the previous month, allowing her to work a full shift with another nurse who showed her how to care for that patient. Respondent felt that kind of one-on-one training prepared her to work alone, and she expected to receive the same kind of training before working alone with the Patient. Respondent said she was surprised to find that the LVN from the day shift was leaving shortly after Respondent's arrival, and she did not feel that the quick orientation she received from the LVN at shift-change was sufficient to train her on the Patient's care.

Respondent pointed out that the LVN who trained her was also inexperienced. Respondent did not know it at the time, but the LVN had not worked with the Patient before August 18, 2018. The LVN received her own patient orientation at the start of her shift that morning. The Patient's medical records indicate that the LVN was trained by a supervisor who remained and worked with the LVN for over four hours, beginning at 9:00 a.m. The supervisor's notes from 1:34 p.m. states:

> I left the home. Orientating nurse is confident and qualified to care for this pt. I asked if she had and questions or concerns over anything regarding the pt. She stated "no". I told her the next nurse is coming to the home at 5pm and to orient her to the case. Go over trach care, vent . . . . I told her to train the new nurse as I trained her today. She said "yes".[31]

---

[30] Staff Ex. 8 at 16.

[31] Staff Ex. 5 at 136.

According to Respondent, the training provided to the LVN shows that her supervisors understood that several hours of orientation were needed to prepare a new nurse to care for the Patient, and Thrive did not make any arrangements to ensure that she received such training.

Despite her concerns about being left alone with the Patient, Respondent testified that she felt she had no choice at the time but to stay. Respondent was trained she could not abandon a patient, and she knew the Patient's parents were depending on her to provide overnight care. The Thrive offices were already closed when her shift began, so Respondent doubted anyone at Thrive would be available to help even if she had called to raise concerns about her ability to care for the Patient. Additionally, Respondent testified that she felt pressured to accept the assignment because Thrive had told her she would not be scheduled for permanent shifts until she had completed a prn (as needed) shift with the Patient.

For the same reason, Respondent said she did not try to call Thrive after hours to report the taped IPV equipment. Additionally, she noted that the Patient's medical records show two IPV treatments had already been administered that day, including one that the supervising nurse had administered.[32] Also, the LVN told Respondent that the Patient's father had been the one to tape the equipment. Because Thrive and the Patient's father seemed accustomed to using the equipment in that condition, Respondent did not consider the taped IPV device to be "malfunctioning" under the circumstances.

Respondent testified that when she administered the Patient's IPV treatment and the Patient desaturated, events unfolded too quickly for her to call a supervisor to ask for help. Then, when the pulse oximeter began alarming, she focused on trying to get a reading on the device. Once Respondent alerted the Patient's father to the situation, he arrived first at the Patient's bedside and remained there, which Respondent felt prevented her from stepping in to change the Patient's trach tube or provide other emergency care. Respondent left the room to get the Patient's mother, as the father instructed. Respondent said she allowed the father to change the trach tube because she

---

[32] Staff Ex. 5 at 111, 136.

knew he had done it before and believed that, having cared for the Patient her whole life, he was competent to do so. However, Respondent acknowledged that the Patient's treatment plan called for the skilled nurse, not a parent, to change the trach tube. It also called for the nurse to call 911 in an emergency, but it was the Patient's father, not Respondent, who called 911.

Respondent asserted that, throughout her shift, she had continuously assessed the Patient and made observations about the Patient's capillary refill, skin coloring, secretions, lung sounds, and status. She acknowledged some that some details were not included in her nursing notes from that evening. Respondent had several explanations for why these details were not retained in her nursing notes. She explained that the iPad used for keeping notes was broken, which prevented her from making contemporaneous electronic notes during her shift and required her to make written notes instead. Then, because the emergency arose, she was not able to complete her notes until the following day. Respondent also contended that her nursing notes had been edited by someone at Thrive after she made them, and said her original notes contained more details than the records that were admitted into evidence at the hearing. Specifically, she recalled making a log that recorded her hourly suctioning of the Patient and said she also documented the patient's respiratory status throughout her shift, but those records were not included in the Patient's medical records.

Respondent has continued working as a nurse since the incident with the Patient. She testified that she worked for several home-health agencies in the months following the Patient's death. Since March 2019, she has worked for Aveanna Epic. Her current employer does not take DNR patients, Respondent explained, indicating that her clients are not as fragile or demanding as the Patient was.

Respondent testified that she feels a strong sense of responsibility for her patients, and considers it her duty to provide the best care she can, to the best of her abilities. She agrees that she was not qualified or adequately trained to care for the Patient and she should not have accepted the assignment. If faced with same situation today, Respondent said she would call her agency to tell them she was not qualified to care for the Patient and she would not remain for the shift. She

also said that, if she encountered IPV equipment held together with tape, she now knows not to use the IPV in that state and would call her supervisor to ask if the IPV could be replaced or if she could use the nebulizer instead.

C. Ms. Franz's Testimony

Ms. Franz has been a licensed RN since 2011 and an APRN since 2014, and has been a Nursing Practice Consulting for the Board since January 2019. She testified as an expert on the Board's laws and rules and offered opinions on the appropriate sanction in this case.

According to Ms. Franz, it is critical for a nurse to have adequate training on respiratory care before caring for someone with such complex needs as the Patient. Otherwise, the nurse will not be prepared to respond appropriately if an intervention is needed. The nurse must understand how and when to use, or discontinue, the ventilator and other equipment. Ms. Franz explained that, before accepting an assignment with a new patient who has a lot of complex needs, a nurse may need more time to orient to the patient. Failing to do so constitutes unsafe practice.

Ms. Franz was sympathetic to the difficult position Respondent found herself in when she realized she was undertrained to care for the Patient, and she agreed with HHSC's determination that Thrive failed to adequately train and supervise Respondent. Still, Ms. Franz explained that nurses must be advocates for their patients at all times, and an advocate would not accept an assignment she could not adequately and competently fulfill. Under those circumstances, according to Ms. Franz, Respondent was required to call her supervisor and voice her concerns. Even if Respondent was correct in assuming that the supervisor would not be happy to hear from her after hours, as her Patient's advocate, Respondent was nonetheless required to insist on having a conversation to determine what could be done to make the Patient safer, in Ms. Franz's opinion.

Ms. Franz testified that the Patient's medical records indicated the Patient's oxygen saturation twice dropped in response to IPV treatments administered by Respondent, which harmed the Patient. Respondent should have stopped the treatment and reassessed the Patient's

needs, but failed to do so. Respondent should also have done a better job of documenting her assessments, according to Ms. Franz. She testified that she could not tell from the medical records why the second IPV treatment (with budesonide) was administered, or whether Respondent considered administering the budesonide with the nebulizer rather than the IPV machine. Ms. Franz also felt the records lacked detail to indicate whether the Patient's secretions were blocking her airflow, whether the Patient needed or responded to suctioning, and whether the Patient's airway pressures were normal. Ms. Franz also testified that, in her opinion, Respondent should have responded when the Patient's respiratory status declined, rather than stepping aside and letting the Patient's father call the ambulance and try to change the trach tube.

Ms. Franz also testified regarding the sanction she felt was warranted for the violations in this case. That testimony is summarized below, in § IV.D discussing the recommended sanction.

IV. ANALYSIS

A. Charge I: Accepting Assignment for Which Respondent was Unqualified

For Charge I, Staff alleges that Respondent violated minimum nursing standards and engaged in unprofessional conduct by accepting the assignment to care for the Patient despite lacking sufficient orientation and training.

Respondent concedes that her conduct violated the minimum nursing standard in Board Rule 217.11(1)(T), which requires a nurse to accept "only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability." She also concedes that by violating this nursing standard, she engaged in unprofessional conduct as defined by Board Rule 217.12(1)(A). Additionally, Respondent agrees that she engaged in unprofessional conduct

as defined by Board Rule 217.12(1)(E), because her acceptance of the assignment to care for the Patient "could be reasonably expected to result in unsafe or ineffective client care."[33]

Staff also contends—and the ALJ agrees—that by accepting the assignment and by not calling Thrive for help when she realized that her orientation was inadequate, Respondent failed to implement measures to promote a safe environment for the Patient and failed to collaborate with members of the heath care team in the interest of the Patient's healthcare, in violation of the minimum standards in Board Rule 217.11(1)(B) and (1)(P). This also evinced a failure to conform to the Board's rules, in violation of the minimum standard in Board Rule 217.11(1)(A).

Additionally, the preponderance of the evidence established Staff's claim that by accepting the assignment to care for a patient when she was not adequately trained, Respondent failed to conform to generally accepted nursing standards in her practice setting, and her conduct could have endangered the Patient's life, health, or safety. Consequently, her conduct constituted unprofessional conduct as defined by Board Rule 217.12(1)(B) and 217.12(4).

Respondent is therefore subject to discipline by the Board pursuant to Code § 301.452(b)(10) for engaging in unprofessional conduct, and pursuant to Code § 301.452(b)(13) for failing to meet minimum standards of nursing practice with respect to Charge I.

B. Charge II: Improper Use of the IPV Machine

For Charge II, Staff alleges that Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to report the taped IPV equipment as malfunctioning, and by continuing to use the machine when the patient was not tolerating the IPV treatment. Staff also alleges that Respondent's nursing notes omitted details about the IPV treatments she administered.[34] Respondent disputes all of the violations alleged in Charge II.

---

[33] Respondent's Closing Argument at 6.

[34] Staff's Closing Argument at 6. While Board Rule 2177.11(1)(D) was cited, there were no factual allegations relating to recordkeeping in Charge II of the Formal Charges. Staff Ex. 4 at 6.

It is undisputed that tape was used on the IPV machine in some manner, but the evidence failed to show that this rendered the equipment unusable or caused it to malfunction. Instead, the preponderance of the evidence shows that Thrive and the Patient's parents knew the machine was taped well before Respondent's shift, and they had been using it in that condition without incident. The medical records show the taped IPV machine had been used twice that day before Respondent arrived—including one treatment administered by a supervising nurse from Thrive who was training an LVN on how to care for the Patient—and those treatments were successfully completed. And, though Respondent had difficulty when she administered IPV treatments, nothing in the evidence suggests that the problems were attributable to the tape on the equipment. Therefore, Staff has not shown that Respondent should not have used the IPV machine or that that the IPV machine was defective or malfunctioning such that Respondent should have reported it to Thrive at the start of her shift.

Staff next claims that after the Patient desaturated during the first IPV treatment, Respondent should have stopped using the IPV machine and switched to administering breathing treatments via nebulizer instead of attempting a second IPV treatment. In her closing brief, Respondent argues that the records show this is, in fact, what she did. Pointing to the interview she gave to an HHSC surveyor about 10 days after the incident, Respondent claims she "stopped the albuterol, put the patient on oxygen, but then finished the treatment [with budesonide] by nebulizer."[35] The relevant portion of the surveyor's interview summary states:

> [Respondent] was asked what time she started the IPV Treatment, she replied "12:48 a.m.[36] I started the Albuterol Neb treatment, she tolerated the treatment well. I waited for 20 mins, suctioned and checked the Trach. I started the second treatment."
>
> [Respondent] was asked to state the name of the second IPV Treatment/medication she administered to the client, she replied, "It starts with letter 'B,' let me check my notes." [Respondent] did not state the name of the medication she administered

[35] Respondent's Closing Brief at 7.

[36] Respondent's nursing notes from that evening indicate that the albuterol IPV treatment was actually administered about half an hour earlier, at 12:15 a.m., and the second treatment was administered from 12:45-12:48 a.m. Staff Ex. 5 at 45.

> and continued with her narration of the events. "During the second IPV Treatment, the client's heart rate and oxygen saturation went down, so I put the client on oxygen . . . the day nurse instructed me to put on the oxygen when the client's heart went down." [Respondent] was asked to state the numbers of the client's heart rate and exigent saturation readings which she observed on the pulse oximetry monitor during the administration of the second IPV treatment, Nurse replied, "The client's heart rate was 60, the oxygen saturation was a bit low, I don't remember."[37]

In the interview summary, Respondent goes on to describe administering oxygen for about a minute, which caused the Patient's heart rate and oxygen level to return to normal. Then she is quoted as saying, "I removed the IPV machine, kept it at the corner and connected the client back to the ventilator."[38]

Contrary to Respondent's closing argument, her statement to the surveyor does not indicate that Respondent switched to a nebulizer to administer budesonide, the second breathing treatment. Rather, her statement, as relayed by the surveyor, indicates that she referred to the budesonide as "the second IPV treatment," administered after the albuterol. Her statement also contradicts Respondent's nursing notes and her testimony at the hearing, both of which acknowledged that the Patient had not tolerated the first IPV treatment well. By administering budesonide as an IPV treatment, Respondent deviated from the Patient's treatment plan, which indicated IPV should be used only "as tolerated by the Patient," and that breathing treatments should be administered by nebulizer if the Patient did not tolerate the IPV treatments.[39] This was also likely to harm the Patient, as the improper administration of her breathing treatments caused the Patient to desaturate a second time.

In failing to follow the treatment plan and administering budesonide by IPV instead of nebulizer when the Patient was not able to tolerate IPV treatments, Respondent failed to: conform to the rules affecting her area of nursing practice; implement measures to promote a safe environment for the Patient; correctly administer the Patient's medications and treatments; institute

---

[37] Staff Ex. 7 at 152 (ellipsis in original).

[38] Staff Ex. 7 at 153.

[39] Staff Ex. 5 at 6-8, 33.

appropriate nursing interventions necessary to stabilize the Patient's condition or prevent complications; and determine the Patient's needs by evaluating her responses to nursing interventions. This violated the minimum nursing standards in Board Rule 217.11(1)(A)-(C), (M), and (3)(A), and constituted unprofessional conduct as defined by Board Rule 217.12(1)(A).

Staff also alleges that Respondent should have called her supervisor, the Patient's physician, or 911 to report a change in the Patient's condition following the IPV treatments. Thrive policy required a nurse to call the office or a supervisor to report "significant change in condition of the patient,"[40] and the Patient's treatment plan directed the nurse to assess the Patient's respiratory status throughout her shift— including checking for secretions, oxygen saturations, and cyanosis—and to "NOTIFY MD OF [SIGNS OR SYMPTOMS OF] RESPIRATORY DISTRESS/INFECTION/ASPIRATION AND FINDINGS OUTSIDE OF PATIENT'S NORMAL LIMITS."[41] When the IPV treatments were administered, Respondent recorded pulse and oxygen saturation levels that were well below the Patient's normal limits. The ALJ agrees that Respondent's failure to notify Thrive or the Patient's physician of these desaturation events constituted a violation of the nursing standard in Board Rule 217.11(1)(P), which requires a nurse to collaborate with members of a client's health care team in the interest of the client's health care.

For the same reasons discussed above, Respondent failed to conform to generally accepted nursing standards in her practice setting, and her conduct could have endangered the Patient's life, health, or safety. Consequently, her conduct additionally constituted unprofessional conduct as defined by Board Rule 217.12(1)(B) and 217.12(4). Respondent is therefore subject to discipline by the Board pursuant to Code § 301.452(b)(10) for engaging in unprofessional conduct, and pursuant to Code § 301.452(b)(13) for failing to meet minimum standards of nursing practice with respect to these allegations in Charge II.

---

[40] Staff Ex. 10 at 1-3.

[41] Staff Ex. 5 at 6.

Staff also claims that Respondent's nursing notes lacked specificity about when the IPV treatments were administered and what rescue measures (*i.e.*, supplemental oxygen) were administered in response, and that this violated the minimum standards in Board Rule 217.11(1)(D). However, the nursing notes include several oxygen saturation and pulse rates recorded between 12:15 a.m. and 12:48 a.m., and those readings correspond to the figures given in Respondent's narrative nursing note from that night. Taken together, they reflect that the first IPV treatment was given at approximately 12:15 a.m., oxygen was administered about a minute later, the second IPV treatment was given at 12:45 a.m., and oxygen was administered a second time at 12:48 a.m.[42] Staff has not shown how these notes were deficient.

C. Charge III: Failure to Assess Patient's Respiratory Status and Failure to Document Assessment of Heart Rate

For Charge III, Staff alleges that Respondent failed to assess the Patient's respiratory status before and after administering IPV treatments, and that she failed to document the patient's heart rate after the pulse oximeter alarm indicated there was no pulse. Respondent conceded that she may have failed to document her assessments "in limited instances" in her medical records in violation of the minimum standard in Board Rule 217.11(1)(D), which likewise constitutes a violation of 217.12(1)(A),[43] so the record-keeping claims will not be addressed further. Respondent otherwise denies the violations asserted in Charge III.

Regarding the claim that Respondent failed to assess the Patient's respiratory status, Respondent asserts that she did properly assess the Patient throughout the IPV treatments and the emergency that unfolded afterward. However, the evidence shows that Respondent failed to perform a comprehensive assessment after the Patient desaturated during the IPV treatments and, even more crucially, when the Patient's pulse oximeter alarm sounded shortly after the IPV treatment. Had Respondent properly checked the Patient's lung sounds, capillary refill, or skin

---

[42] Staff Ex. 5 at 45, 48.

[43] Respondent's Closing Brief at 9.

color before or after IPV treatments, she likely would have realized that the Patient was actually in respiratory distress.

Respondent also failed to appreciate that the alarming pulse oximeter indicated that the Patient did not have a pulse. This should have prompted her to call 911, Staff argued. Instead, Respondent tried repeatedly to get a reading on the pulse oximeter, futilely placing the sensor on different extremities on the Patient before incorrectly concluding that the pulse oximeter had failed. In her testimony at the hearing, Respondent acknowledged that she focused her attention on addressing the perceived equipment failure and could have missed other indicators that the patient was not breathing. Additionally, both of the Patient's parents commented to HHSC's investigator that Respondent did not appear panicked when she awoke them to ask for help with the pulse oximeter.[44] This is further evidence that Respondent did not understand the Patient had stopped breathing. This was another failure to accurately assess the Patient and respond appropriately to the emergency.

Staff does not allege that Respondent's failures directly caused the Patient's death,[45] but does allege that her failure to accurately assess the Patient's breathing status and respond to the alarming pulse oximeter endangered the Patient's life. The ALJ agrees. These lapses establish that Respondent failed to: conform to the rules affecting her area of nursing practice; implement measures to promote a safe environment for the Patient; institute appropriate nursing interventions necessary to stabilize the Patient's condition or prevent complications; and properly evaluate the Patient's responses to nursing interventions. This violated the minimum nursing standards in Board Rule 217.11(1)(A)-(B), (M), and (3)(A), and constituted unprofessional conduct as defined by Board Rule 217.12(1)(A). For the same reasons, Respondent failed to conform to generally accepted nursing standards in her practice setting, and her conduct could have endangered the Patient's life, health, or safety. Consequently, her conduct additionally constituted unprofessional

---

[44] Staff Ex. 7 at 15-16.

[45] In its post-hearing brief, Staff did argue that Respondent's conduct led directly to the Patient's demise. Staff's Response to Respondent's Closing Argument at 9. However, this assertion directly contradicted Ms. Franz's testimony and Staff's position at the hearing.

conduct as defined by Board Rule 217.12(1)(B) and 217.12(4). Respondent is therefore subject to discipline by the Board pursuant to Code § 301.452(b)(10) for engaging in unprofessional conduct, and pursuant to Code § 301.452(b)(13) for failing to meet minimum standards of nursing practice with respect to these allegations in Charge III.

Addressing Charge III in its brief, Staff additionally argues that Respondent's "second administration of medication using the IPV machine indicates a lack of understanding of the rationale for, effects of[,] and how to correctly administer the IPV treatment in violation of Board [R]ule 217.11(1)(C)."[46] A similar argument was made with respect to Charge II, and the ALJ has already found a violation of Board Rule 217.11(1)(C) relating to administration of the IPV treatments. The evidence did not establish a separate violation of this rule with respect to Charge III.

D. Sanction Analysis

Staff contends that, whether Respondent's conduct is sanctioned as violations of minimum nursing standards under Code § 301.452(b)(13) or as unprofessional conduct under Code § 301.452(b)(10), a Second Tier, Sanction Level II classification is appropriate under the Disciplinary Matrix. The ALJ agrees.

As set described in Ms. Franz's testimony, in sanctioning pursuant to Code § 301.452(b)(13), the second tier of the Disciplinary Matrix is the level designated for conduct that falls below nursing standards and that causes patient harm or poses a risk of patient harm.[47] According to Ms. Franz, the first tier does not apply because Respondent's actions did cause or threaten harm to the Patient, while the first tier is restricted to violations with no such risk. Ms. Franz also did not think the third tier—which applies to conduct that poses a serious risk of

---

[46] Staff's Closing Brief at 10.

[47] 22 Tex. Admin. Code § 213.33(b).

harm or death that is known or should be known to the nurse[48]—was warranted because, in Ms. Franz's opinion, there was no established or direct causal link between Respondent's actions and the Patient's demise. Ms. Franz also did not think that Respondent could have predicted the Patient's outcome, and so her inexperience and lack of training were factors that placed the violations most appropriately in the second tier.

Similarly, as a sanction pursuant to Code § 301.452(b)(10) for Respondent's alleged unprofessional conduct, Ms. Franz opined that an appropriate sanction would be in the second tier of the Disciplinary Matrix, the level for violations that result in serious risk to patient or public safety. The first tier applies only to isolated failures with no adverse patient affects, and Respondent's multiple violations and the actual harm to the Patient make this level inapplicable. While the third tier could potentially apply, Ms. Franz felt Respondent's circumstances place her violations more appropriately in the second tier.

Within the second tiers for both failures to conform to minimum standards and unprofessional conduct, the Board must select Sanction Level I or II, based upon the aggravating and mitigating factors in the Disciplinary Matrix and those listed in Board Rule 213.33(c). As aggravating factors here, Ms. Franz pointed to the fact that there were multiple violations, and that actual harm to the Patient did result from Respondent's actions. The Patient's vulnerability is also an aggravating factor that makes Respondent's violations more serious. Ms. Franz testified that Respondent's main goal in caring for a ventilator-dependent patient was to maintain an open airway, and Respondent failed at that here.

The parties also pointed to a number of mitigating factors that suggest a lesser sanction is warranted. Respondent argued, and Ms. Franz agreed, that Respondent was a new nurse and therefore inexperienced, and she was working independently in a home setting where she did not have ready access to a supervisor who could help her. She was also working with an unfamiliar patient with very complex needs. New nurses "don't know what they don't know," according to

---

[48] 22 Tex. Admin. Code § 213.33(b).

Ms. Franz, and sometimes cannot anticipate complications or outcomes they have not yet encountered. For this reason, Ms. Franz noted that the Board recommends against (but does not forbid) new nurses working in home health settings. Ms. Franz also agreed with Respondent that systemic problems at Thrive—namely, Thrive's failure to provide adequate training and orientation—contributed to Respondent's violations. The parties agree there was no evidence that Respondent ever misrepresented her knowledge, experience, training, or skills or was untruthful. Respondent also has no prior disciplinary history with the Board, and there is no evidence of any other negative practice history beyond the allegations in this case, even though Respondent has continued to work in home health settings since the event.

While a Sanction Level I could result in only a warning or reprimand with stipulations, Sanction Level II could result in a suspension or revocation of the nurse's license.[49] Staff argues that given the seriousness of the violations and the harm to the Patient, a Sanction Level II is appropriate, though the mitigating factors support a lower sanction within that level. Respondent contends that the mitigating factors should lead to a finding that Sanction Level I applies. Taking the aggravating and mitigating factors into consideration, the ALJ agrees with Staff that Respondent's violations best fit under Sanction Level II, whether the sanction is assessed pursuant to Code § 301.452(b)(10) or (13).

As a sanction, Ms. Franz did not recommend revoking Respondent's license. Rather, she testified that a two-year suspension, partially probated, would remediate Respondent's practice. She recommended that the suspension be enforced until Respondent completed the following remedial education:

- A nursing jurisprudence and ethics course, a live course that is 6-7 hours in length;
- A physical assessment course, intended to ensure that Respondent can accurately detect and assess changes in her patients' conditions. This course typically entails 6 hours in a classroom, with a 64-hour clinical component;
- A critical thinking course, a 3-4 hour online class; and

[49] 22 Tex. Admin. Code § 213.33(b).

- A documentation course, a 6-hour live course to reinforce the need for a nurse to document changes in patient.

Upon completion of those courses, Ms. Franz felt that the suspension of Respondent's license could be probated provided that Respondent complied with stipulations requiring her to notify her current and future employers regarding Board order that results from this proceeding; and submit to direct supervision for the first year of probation and indirect supervision for second year. These stipulations will help ensure that Respondent has an experienced nurse available to answer her questions and provide mentorship. Ms. Franz acknowledged that the supervision component would conflict with Respondent's current employment because it would exclude her from working in independent practice settings such as home health or hospice, and would require her to be regularly employed, not employed by an agency doing temporary (prn) work. The ALJ agrees that these requirements and stipulations are reasonably targeted to address the violations and ensure that Respondent is safe to practice independently again.

Accordingly, the ALJ concludes the Board should find Respondent's conduct to be a Second Tier, Sanction Level II offense under both Code § 301.452(b)(10) and (13), and recommends a two-year suspension of Respondent's license, with educational requirements and appropriate stipulations that must be met before the suspension can be probated. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

V. FINDINGS OF FACT

1. Christianah Bello (Respondent) holds Registered Nurse (RN) License No. 938895, issued by the Texas Board of Nursing (Board) on February 6, 2018.

2. After receiving her RN license Respondent began working as a private-duty nurse for Thrive Skilled Pediatric Care (Thrive) in Conroe, Texas. In April 2018, she moved to Thrive's Houston location.

3. On August 18, 2018, Respondent was assigned to an overnight shift providing in-home care for an eight-year-old patient (the Patient) who was paralyzed in a vegetative state. The Patient was dependent on a ventilator and had a tracheostomy (trach) where the ventilator connected to her windpipe.

4. The Patient died during Respondent's overnight shift on August 18-19, 2018.

5. Board staff (Staff) investigated Respondent's care of Patient. On February 21, 2020, Staff docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas, for assignment of an Administrative Law Judge (ALJ).

6. On May 5, 2020, 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.

7. On June 23, 2020, ALJ Sarah Starnes convened a telephonic hearing before SOAH.. Assistant General Counsel Helen Kelley represented Staff. Respondent was represented by attorney Marc Meyer. The record closed on August 3, 2020, after the parties filed written closing arguments.

Charge I

8. The Patient had received private nursing services from Thrive since at least January 2018, but the overnight shift from August 18-19, 2018 was the first time Respondent had been assigned to work with the Patient.

9. Respondent received only a general orientation when she was hired by Thrive's Conroe office, and did not receive any additional orientation or training when she moved to the Houston location.

10. Before her shift with the Patient, Respondent had previously cared for several other patients on ventilators, and she had been generally trained on how to replace a trach tube, but she had never performed a replacement on one of her patients or been faced with a trach emergency.

11. When she arrived for her shift, the licensed vocational nurse (LVN) who had worked the day shift gave Respondent a short, approximately twenty-minute orientation before leaving Respondent alone to care for the Patient. This was the only orientation Respondent received on the Patient's care.

12. Typically, Respondent would receive at least several hours of orientation on a new patient and would sometimes work a full shift alongside another nurse before working independently with a fragile and medically complex patient.

13. The LVN who trained Respondent had also never worked with the Patient before that day.

14. The quick orientation she received from the LVN at shift-change was not sufficient to train Respondent on the Patient's care, and Respondent felt unprepared to care to for such a complex and fragile patient.

15. Respondent felt she would be abandoning the Patient to refuse the assignment. Because Thrive offices were already closed, she felt it would be futile to call Thrive to ask for help.

16. Respondent accepted the assignment to care for the Patient despite lacking sufficient orientation and training.

17. Respondent's acceptance of the assignment to care for the Patient could be reasonably expected to result in unsafe or ineffective client care.

18. In accepting the assignment to care for the Patient and by not calling Thrive for help when she realized that her orientation was inadequate, Respondent failed to implement measures to promote a safe environment for the Patient.

19. By not calling Thrive for help when she realized that her orientation was inadequate, Respondent failed to collaborate with members of the heath care team in the interest of the Patient's healthcare.

Charge II

20. The Patient's treatment plan directed her skilled nurse to continuously monitor the Patient by pulse oximetry, and to perform intrapulmonary percussive ventilation (IPV) treatments three times a day, as needed and as tolerated by the Patient. The treatment plan stated that nebulizer treatments could be given if the Patient did not tolerate the IPV treatments.

21. The treatment plan directed the skilled nurse to check all equipment at the beginning and end of the shift for any malfunctioning equipment.

22. The treatment plan directed the skilled nurse to check the Patient's respiratory status throughout her shit and to notify the physician if she saw signs or symptoms of respiratory distress or any findings outside the Patient's normal limits.

23. Thrive policy required a nurse to call the office or a supervisor to report any "significant change in condition of the patient."

24. The Patient's IPV machine was held together by tape, which had been applied by her father.

25. Thrive and the Patient's parents knew the machine was taped well before Respondent's shift, and had been using it in that condition without incident.

26. Prior to Respondent's shift, the taped IPV machine had been used twice that day—including one treatment administered by a supervising nurse from Thrive—and those treatments were successfully completed.

27. The evidence did not show that the tape rendered the IPV machine defective or malfunctioning such that Respondent should have reported it to Thrive at the start of her shift.

28. At approximately 12:15 a.m., Respondent administered an IPV treatment with albuterol, a breathing treatment. About three minutes after starting the IPV treatment, the Patient's heart rate and oxygen saturation levels dropped significantly below her normal limits. In response to this desaturation, Respondent administered supplemental oxygen and the Patient's heart rate and pulse oxygen returned to a normal range within about a minute.

29. At about 12:45, a.m., Respondent tried to administer a second IPV treatment, this time with budesonide, an alternative breathing treatment. As the budesonide was administered, the Patient's heart rate and pulse oxygen fell again, which again required Respondent to administer oxygen to raise them. The Patient's heart rate and pulse oxygen returned to a normal range within about three minutes of the second desaturation.

30. Respondent's nursing notes indicate the Patient did not tolerate the IPV treatment. The evidence did not show her notes regarding the IPV treatments were inadequate.

31. Respondent did not call Thrive or the Patient's physician to report the Patient's desaturation during the two IPV treatments.

32. Respondent failed to collaborate with members of the Patient's health care team following the desaturation events.

33. By administering budesonide as an IPV treatment after the Patient had not tolerated the administration of albuterol by IPV, Respondent deviated from the Patient's treatment plan.

34. Administering the second breathing treatment by IPV machine rather than by nebulizer was likely to harm the Patient.

35. By administering the second breathing treatment by IPV machine rather than by nebulizer, Respondent failed to implement measures to promote a safe environment for the Patient.

36. By administering the second breathing treatment by IPV machine rather than by nebulizer, Respondent failed to correctly administer the Patient's medication

37. By administering the second breathing treatment by IPV machine rather than by nebulizer, Respondent failed to institute appropriate nursing interventions necessary to prevent complications.

38. By administering the second breathing treatment by IPV machine rather than by nebulizer, Respondent failed to appropriately evaluate the Patient's responses to nursing interventions.

Charge III

39. After determining that the Patient appeared fine after the two desaturation events, Respondent left the Patient's bedside to clean the IPV equipment in the adjacent bathroom.

40. Respondent failed to perform a comprehensive assessment after the Patient desaturated during the IPV treatments.

41. Within about five minutes, the Patient's pulse oximeter began alarming, indicating that no pulse was registering on the device.

42. In response to the alarm, Respondent returned to the Patient and saw secretions coming from the Patient's mouth and nose, and tried to suction them. She still could not get a reading on the pulse oximeter, despite moving the sensor to several different extremities.

43. Respondent tried to take the Patient's pulse manually, and thought she detected a weak pulse on her wrist, even though nothing was registering on the pulse oximeter.

44. Respondent failed to perform a comprehensive assessment after hearing the pulse oximeter alarm, and instead incorrectly concluded that the pulse oximeter sensor had failed.

45. Because she focused on the perceived equipment failure, rather than the Patient's physical condition, Respondent did not notice that the Patient was not breathing.

46. The evidence did not establish why the Patient stopped breathing, whether because her trach tube was dislodged or due to some other cause.

47. Respondent went upstairs to ask the Patient's parents where to find another pulse oximeter sensor.

48. The Patient's father ran down the stairs and arrived at the Patient's bedside ahead of Respondent. He saw that the Patient was turning blue and called an ambulance.

49. The Patient's father believed the Patient's trach tube had become dislodged and tried to change the tube using spare equipment by the Patient's bedside while they waited for the ambulance to arrive. This did not restore the Patient's pulse or oxygen levels.

50. The Patient's mother found a replacement sensor for the pulse oximeter and confirmed it was working by testing it on herself, but she still could not get a reading from the Patient.

51. When the ambulance arrived, the EMTs tried to use their own equipment to detect a pulse but found none. The mother told them that the Patient had a "do not resuscitate" order, and she turned off the Patient's ventilator.

52. The same night, police and Child Protective Services were called to investigate the Patient's death, and Respondent and the parents were all interviewed for several hours. Respondent was not able to complete her nursing notes from the shift until later that morning, on August 19, 2018.

53. The Patient's death was investigated by Thrive and other agencies, including the Texas Department of Family and Protective Services and Texas Health and Human Services Commission (HHSC), which both regulate aspects of home health care.

54. Thrive was cited for numerous violations, including inadequately training Respondent when she was hired and failing to ensure that Respondent received adequate in-home orientation and training prior to caring for the Patient.

55. Respondent's failure to accurately assess the Patient's breathing status and respond to the alarming oximeter endangered the Patient's life.

56. By failing to accurately assess the Patient's breathing status and respond to the alarming oximeter, Respondent failed to implement measures to promote a safe environment for the Patient.

57. By failing to accurately assess the Patient's breathing status and respond to the alarming oximeter, Respondent failed to institute appropriate nursing interventions necessary to stabilize the Patient or prevent complications.

58. By failing to accurately assess the Patient's breathing status and respond to the alarming oximeter, Respondent failed to appropriately evaluate the Patient's responses to nursing interventions.

Aggravating/Mitigating Factors

59. Respondent has continued working as a nurse since the incident with the Patient. She worked for several home-health agencies in the months following the Patient's death, and has worked for Aveanna Epic since March 2019.

60. Respondent acknowledges that she was not qualified or adequately trained to care for the Patient and she should not have accepted the assignment.

61. If faced with same situation today, Respondent would call her agency to tell them she was not qualified to care for the Patient and she would not remain for the shift.

62. Though this case involved only one incident, Respondent's conduct constituted multiple violations.

63. The patient's vulnerability is an aggravating factor related to Respondent's conduct.

64. Respondent's conduct caused harm to the Patient, but there was no established causal link between Respondent's actions and the Patient's demise.

65. Respondent's inexperience and lack of training contributed to the violations, and made her unable to predict the outcome of her actions and responses with the Patient.

66. Thrive's failure to provide Respondent with adequate training, orientation, or support contributed to the violations.

67. Respondent has not misrepresented her knowledge, experience, training, or skills, and she was not untruthful.

68. Respondent has no prior disciplinary history with the Board, and there is no evidence of any other negative practice history either before or after the event.

VI. 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. By accepting the assignment to care for the Patient despite lacking sufficient orientation and training, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A), (B), (P), and (T), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code § 217.12(1)(A), (B), (E), and (4).

6. By administering budesonide by IPV instead of nebulizer after seeing that the Patient was not able to tolerate IPV treatments, and by failing to report the desaturation events to the Patients medical team, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A)-(C), (M), (P), and (3)(A), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code § 217.12(1)(A), (B), and (4).

7. By failing to accurately assess the Patient's breathing status, appropriately respond to the alarming pulse oximeter, and accurately document her assessments, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A)-(B), (D), (M), and (3)(A), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code 217.12(1)(A), (B), and (4).

8. For violating minimum nursing standards, Respondent is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(13).

9. For engaging in unprofessional conduct, Respondent is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(10).

10. 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).

11. 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(c) and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(b).

12. Respondent's conduct most appropriately falls in the Second Tier, Sanction Level II of the Disciplinary Matrix under both Code § 301.452(b)(10) and (13). 22 Texas Admin. Code § 213.33(b).

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board suspend Respondent's RN license for two years, with appropriate stipulations and with educational requirements that must be met before the suspension can be probated.

SIGNED August 14, 2020.

Sarah Starnes

SARAH STARNES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS