



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.

Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 941448	§	
issued to DIMPLE DARL CORTEZ YATAR	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of DIMPLE DARL CORTEZ YATAR, Registered Nurse License Number 941448, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on December 11, 2020.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.
3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.
4. Respondent received a Diploma in Nursing from The Philippines, on March 1, 2008. Respondent was licensed to practice professional nursing in the State of Texas on March 23, 2018.
5. Respondent's nursing employment history includes:

4/2018 – 1/2019	Registered Nurse	Hendrick Medical Center Abilene, Texas
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Respondent's nursing employment history continued:

2/2019 – 10/2020

Registered Nurse

Abilene Regional Medical Center
Abilene, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, and had been in that position for three (3) months.
7. On or about July 16, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, and while still in orientation, Respondent failed to notify the physician and/or Rapid Response Team when Medical Record Number 877128 had a systolic blood pressure greater than 20mm Hg from baseline, per facility policy. Additionally, Respondent failed to reassess and/or document her reassessment of the patient's oxygen saturation after an initial reading of 90% to verify her interventions of elevating the head of the bed 45 degrees and increasing the Oxygen from 2L to 4L via nasal cannula were sufficient. Subsequently, the patient had a change in neurological status and required transfer to the Intensive Care Unit. Respondent's conduct deprived the physician and/or Rapid Response Team the opportunity to timely provide medical interventions to stabilize the patient and Respondent's conduct was likely to injure the patient from clinical care decisions based on incomplete assessment information.
8. On or about December 9, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, Respondent failed to accurately assess and/or inaccurately documented the neurological status of Patient Medical Record Number 1415380 in that she documented a score of fifteen (15) on the Glasgow Coma Scale which is inconsistent with her documented score of twenty-eight (28) on the National Institute of Health Stroke Scale, which indicates a severe stroke. Respondent's conduct created an inaccurate medical record, and was likely to injure the patient in that subsequent care givers would rely on her documentation to provide further patient care.
9. On or about December 23, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, Respondent inaccurately documented in the chart of Patient Medical Record Number 0498033 that the patient was both alert and oriented x 4 but also disoriented to place, time, and location. Respondent's conduct created an inaccurate medical record, and was likely to injure the patient in that subsequent care givers would rely on her documentation to provide further patient care.
10. On or about December 23, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, Respondent inaccurately documented in Medical Record Number 1443669 in that Medication Tasks indicates Heparin was given in left upper quadrant of abdomen, but the Assessments and Cares document states the administration site was the patient's right arm. Respondent's conduct created an inaccurate medical

record, and was likely to injure the patient in that subsequent care givers would rely on her documentation to provide further patient care.

11. On or about December 24, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, Respondent inappropriately administered Potassium 40 mEq to Patient Medical Record Number 0570767, who had an elevated Potassium level of 5.6. Respondent's conduct was likely to injure the patient from the effects of excessive potassium including abnormal heart rhythms and possibly death.
12. On or about December 24, 2018, while employed as a Registered Nurse with Hendrick Medical Center, Abilene, Texas, Respondent failed to timely administer Potassium Chloride 40mEq to Patient Medical Record Number 0821914 as ordered by the physician. Respondent's conduct was likely to harm the patient from ineffective treatment of low Potassium.
13. In response to Finding of Fact Number Seven (7), Respondent states that she reported all her assessments and interventions to her preceptor who was more experienced and knowledgeable in situations like this, and who was familiar with this patient. Respondent asked her for further evaluation of the patient's condition prior to reporting to physician. She consulted her preceptor first because she believed that she did not have the proper coaching and education and training regarding when to call RRT by herself as a preceptee. After her preceptor assessed the patient, she instructed Respondent to keep monitoring the patient. After an hour of continuous monitoring, Respondent notified her preceptor that the patient was becoming unstable and confused. The preceptor at that time notified the Charge Nurse and called RRT at 1515 and MD was notified at 1537. Respondent states that no harm came to the patient as a result of this.
14. In response to Finding of Fact Number Eight (8), Respondent states that she was still learning and mastering the Apollo charting software. Respondent admits that she should have documented GCS 12 instead of 15, and that she might have clicked in error the orientation section of the GCS assessment, but that her intention was to document that the patient was confused. Respondent states that she did document that the patient was confused in the nurses notes as seen in the record at pdf page # 148. Respondent states that no harm came to the patient as a result of this.
15. In response to Finding of Fact Number Nine (9), Respondent states that she Respondent states that she meant to document that the patient was disoriented to place, time and situation, and admits it was a documentation mistake that she incorrectly documented oriented x4. She states that she did revise it according to her bedside assessment which was disoriented to place, time and situation. However, she wasn't able to change or unclick the alert and oriented X4 on the dropdown menu because while doing so she received another call from another patient that needed her help, and as a result she saved the GCS information and planned to come back to redo it as soon as she was finished with the patient who called her. She states that she did not recall that she needed to review and change her

documentation, and admits that was an error on her part. Respondent states that no harm came to the patient as a result of this.

16. In response to Findings of Fact Number Ten (10), Respondent states that her plan was to give the Heparin in the abdomen but when she was about to give the Heparin, the patient changed her mind and insisted that she give the medication on the right arm, despite giving her the explanations that the medication is best absorbed in the abdomen. She was on her left side lying position, and did not want to move. Respondent states that her knowledge of this Medication is that it can be given subcutaneously on the upper arm, but she did document incorrectly that it was given in the abdomen. Respondent states that no harm came to the patient as a result of this, but she acknowledges that she should have documented the location correctly, by going back to correct it.
17. In response to Finding of Fact Numbers Eleven (11) and Twelve (12), Respondent states that she did report the Potassium levels to the physician, but perhaps she should have called him also, but she thought that he would be coming on his rounds, which he did. Respondent states that no harm came to the patients as a result of this.
18. Formal Charges were filed on August 14, 2019.

19. This Agreed Order resolves all issues associated with SOAH Docket 507-20-2654.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B),(1)(C),(1)(D),(1)(M),(1)(P)&(3)(A) and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)(B),(1)(C)&(4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 941448, heretofore issued to DIMPLE DARL CORTEZ YATAR.
5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **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" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

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

III. UNDERSTANDING BOARD ORDERS

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

IV. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated:**

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

V. **EMPLOYMENT REQUIREMENTS**

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

- A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.
- B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.
- C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse

registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed 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.


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RESPONDENT'S CERTIFICATION

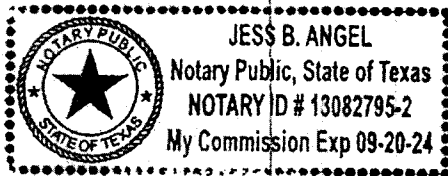
I understand that I have the right to legal counsel prior to signing this Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action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

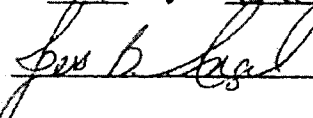
Signed this 18th day of December, 20 20.


DIMPLE QAR CORTEZ YATAR, RESPONDENT

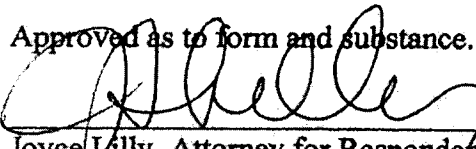
Sworn to and subscribed before me this 18 day of December, 20 20.

SEAL




Notary Public in and for the State of Texas

Approved as to form and substance.


Joyce Lilly, Attorney for Respondent

Signed this 18 day of Dec 20 20

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 18th day of December, 2020, by DIMPLE DARL CORTEZ YATAR, Registered Nurse License Number 941448, and said Agreed Order is final.

Effective this 21st day of January, 2021.

A handwritten signature in cursive script, reading "Katherine A. Thomas".

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