DOCKET NUMBER 507-20-2122

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 227048, ISSUED TO STELLA B. EGUALKHIDE a/k/a STELLA B. CUNNINGHAM	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: STELLA B. EGUALKHIDE
a/k/a STELLA B. CUNNINGHAM
5806 TRANQUIL DAWN
SAN ANTONIO, TX 78218

LEAH H. BRITE
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 21-22, 2021, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's exceptions to the PFD; the ALJ's final letter ruling of November 3, 2020; 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. Staff filed exceptions to the PFD on October 13, 2020. The Respondent did not file any exceptions to the PFD or a response to Staff's exceptions to the PFD. On November 3, 2020, the ALJ issued her final letter ruling, in which she declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; Staff's exceptions to the PFD; the ALJ's final letter ruling of November 3, 2020; 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 I sanction for her violation of §301.452(b)(13)[1]. Either a Warning with Stipulations or a Reprimand with Stipulations is authorized under a second tier, sanction level I sanction[2]. The Board agrees with the ALJ that a Warning with Stipulations is an appropriate sanction in this case.

Respondent's conduct posed a serious risk of harm to the patient[3]. However, the Respondent's conduct was the result of her attempts to comply with the chain of command at the facility. Further, Respondent acknowledged this was a learning experience for her, and she has no prior disciplinary action with the Board[4].

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)(3), that a Warning with Stipulations is the most appropriate sanction in this matter.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course and a critical thinking course.[5] These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas, to assist the Respondent in developing her own critical thinking and judgment, and to prevent future violations from occurring. The Board recognizes that the ALJ did not find sufficient evidence to justify supervised practice in this case[6], and, therefore, declines to impose any supervisory stipulations as part of this Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(3)[7].

IT IS THEREFORE ORDERED that RESPONDENT shall receive the sanction of **WARNING WITH STIPULATIONS** in accordance with the terms of this Order.

I. COMPLIANCE WITH LAW

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[1] See page 7 of the PFD.

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

[3] See page 6 of the PFD.

[4] See page 7 of the PFD

[5] 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.

[6] See page 7 of the PFD and the ALJ's final letter ruling of November 3, 2020.

[7] 22 Tex. Admin. Code §213.33(e)(3), which authorizes reasonable probationary stipulations that may include remedial education courses.

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

II. UNDERSTANDING BOARD ORDERS

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

III. REMEDIAL EDUCATION COURSE(S)

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

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

B. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and*

Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.

IV. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and, 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 21st day of January, 2021.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; Docket No. 507-20-2122 (September 28, 2020)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

September 28, 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. 507-20-2122; Texas Board of Nursing v Stella B. Egualkhide a/k/a Stella B. Cunningham

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,

L Brite

LINDA H. BRITE
Administrative Law Judge

LB/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 (with 1 CD of Hearing on the Merits) – **VIA EFILE TEXAS and INTERAGENCY MAIL**

Stella Egualkhide aka Stella Cunningham, 5806 Tranquil Dawn, San Antonio, TX, 78218– **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-20-2122

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
STELLA B. EGUALKHIDE a/k/a STELLA B. CUNNINGHAM, LVN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) alleges that Stella B. Egualkhide, also known as Stella B. Cunningham, (Respondent) failed to conform to the minimum standards of acceptable nursing practice. Staff seeks sanctions, including a warning, remedial education courses, and indirect supervision for a year.

The Administrative Law Judge (ALJ) determines that Respondent violated minimum standards of nursing practice described in 22 Texas Administrative Code § 217.11(1)(A), (1)C), (1)(M), and (1)(P). The ALJ recommends that the Board issue a warning and require remedial education courses. The ALJ finds that insufficient evidence supported the proposed sanction of indirect supervision.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

The telephonic hearing on the merits convened on August 3, 2020, before ALJ Linda H. Brite. Staff attorney Helen Kelley represented Staff. Respondent appeared and represented herself. On the same day, the hearing concluded and the record closed.

Notice and jurisdiction were not contested. Therefore, those issues are discussed only in the findings of fact and conclusions of law.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

Staff alleges that on July 22, 2018, while employed as a Licensed Vocational Nurse and Charge Nurse at Silver Tree Nursing and Rehabilitation Center, in Schertz, Texas (Facility), Respondent failed to intervene and notify the physician of a medication error and change in condition involving a patient. The patient had missed a dose of blood pressure medication and had elevated blood pressure readings of up to 240/118. Staff further alleges that Respondent's conduct unnecessarily exposed the patient to the risk of harm from complications related to untreated elevated blood pressure.

Pursuant to Texas Occupations Code (Code) § 301.452(b)(13), the Board may discipline a nurse for failure to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm. Board Rule 217.11[1] discusses minimum acceptable standards of nursing practice, including the following:

- Board Rule 217.11(1)(A): A nurse must know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- Board Rule 217.11(1)(C): A nurse must know the rationale and the effects of medications and treatments and shall correctly administer the same;
- Board Rule 217.11(1)(M): A nurse must institute appropriate nursing interventions that might be required to stabilize a patient's condition and/or prevent complications; and
- Board Rule 217.11(1)(P): A nurse must collaborate with the patient, members of the health care team and, when appropriate, the patient's significant other(s) in the interest of the patient's health care.

[1] 22 Tex. Admin. Code § 217.11. For ease of reference, a Board rule found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code is referred to as "Board Rule ____."

Board Rule 213.33 sets out a disciplinary matrix (Matrix) that is intended to match the severity of the sanction imposed to the nature of the violation at issue.[2] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction. The Matrix includes mitigating and aggravating factors that may be considered by the Board in determining the appropriate sanction. In addition, Board Rule 213.33(c) provides a list of factors to be considered in determining the appropriate tier and sanction level of the violation under the Matrix.

Staff must prove its allegations by a preponderance of the evidence.[3]

III. EVIDENCE

Staff presented the testimony of Respondent and Linda Laws and offered nine exhibits, which were admitted. Respondent did not offer any exhibits and testified on her own behalf.

A. Testimony of Respondent

Respondent was employed as a Charge Nurse and Licensed Vocational Nurse (LVN) at the Facility.[4] On July 22, 2018, Respondent was working as a medication aide. On July 22, 2018, the patient was scheduled to have a blood pressure medication, hydralazine, administered at 3:00 p.m.[5] Respondent noticed that the patient was not in her room at 3:00 p.m. for the administration of the medication. Respondent informed the charge nurse, Courtney McCoy (Charge Nurse), about the absence of the patient. The Charge Nurse told Respondent that the patient was out with her family until dinner time.

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[2] 22 Tex. Admin. Code § 213.33(b); *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[3] 1 Tex. Admin. Code § 155.427.

[4] Staff Ex. 6.

[5] The record contains conflicting information about whether the medication was scheduled to be given at 3:00, 4:00, or 5:00 p.m. Based on the physician's orders and the previous administration of the medication at 11:00 a.m., Staff contends that 5:00 p.m. would be the next time the medication should be administered. Staff Ex. 5 at 49.

At 5:00 p.m., Respondent observed the patient in her room and took her blood pressure. The blood pressure reading was 177/72, pulse rate 70. Respondent informed the Charge Nurse about the patient's elevated blood pressure and awaited further orders. Respondent testified that she advised the Charge Nurse to administer the blood pressure medication and inform the doctor for further intervention. The Charge Nurse responded that "she was the charge nurse and [Respondent was] only the med aide."[6] Respondent testified that she followed the Charge Nurse for over two hours to get the Charge Nurse to administer medication to the patient and notify the physician. She stated that the Charge Nurse got angry with Respondent, cursed at her, and told her to "back off."

The physician's orders stated that the physician should be notified if the patient's blood pressure is greater than 150.[7] The medical records indicated that at 7:10 p.m., the patient's blood pressure reading was 240/118, and the Charge Nurse administered hydralazine to the patient.[8] Respondent testified that the Charge Nurse notified the physician only after Respondent told the Charge Nurse that Respondent would call the doctor if the Charge Nurse did not.

Respondent testified that if she were the charge nurse that day, she would have handled things differently. Respondent acknowledged that 240/118 was a dangerously high blood pressure level. Respondent also stated that this had been a learning experience and that she would manage such situations better in the future.

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[6] Staff Ex. 5 at 80-82.

[7] Staff Ex. 5 at 66.

[8] Staff Ex. 5 at 73.

B. Testimony of Linda Laws

Ms. Laws is a registered nurse and has been a nursing consultant with the Board for more than seven years. Ms. laws testified that Board policy allows nurses to work at lower levels but they will always be held to their highest level of education and competency.

Ms. Laws stated that Respondent's violation of Code § 301.452(b)(13) is considered a Second Tier Offense at Sanction Level I under the Matrix. Ms. Laws testified that 240 is an extremely high blood pressure level with a tremendous risk of harm, including heart attack and stroke. Ms. Laws testified that a nurse is always held to her highest level of education and must do the right thing for the patient, including following physician's orders.

Ms. Laws recommended Respondent receive a warning with stipulations including coursework on nursing jurisprudence, medication administration, documentation, critical thinking, and professional accountability. Ms. Laws's recommended sanctions also require that: Respondent notify employers; her employers submit notification of employment forms to the Board; her employers submit quarterly reports for one year; and Respondent undergo indirect supervision for one year.

IV. ANALYSIS

Staff contends that Respondent failed to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm under Code § 301.452(b)(13).

It is uncontroverted that the patient's medication was not administered in accordance with the physician's orders. The physician's orders also required the physician to be notified if the blood pressure was above 150. At approximately 5:00 p.m., Respondent read the patient's blood pressure to be 177/72, which was an elevated blood pressure level that should have prompted notification of the physician. However, Respondent did not notify the physician. Instead, Respondent followed

the Charge Nurse for approximately two hours, advising her to administer the medication and inform the physician.

The record shows that Respondent believed she was not in a position to intervene or contact the physician because she was not the charge nurse that day. Despite her role as a medication aide that day, Respondent still held a responsibility to the patient to utilize her education and training as an LVN to stabilize the patient with elevated blood pressure in a timely manner. The preponderant evidence establishes that Respondent failed to appropriately intervene and notify the physician of the patient's condition.

By failing to intervene and notify the physician of the patient's condition, Respondent: (1) failed to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal state, or local laws, rules or regulations affecting the nurse's current area of nursing practice, in violation of Board Rule 217.11(1)(A); (2) failed to know the rationale and effects of medications and treatments and correctly administer them, in violation of Board Rule 217.11(1)(C); (3) failed to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications in violation of Board Rule 217.11(1)(M); and (4) failed to collaborate with the members of the health care team in the interest of the client's health care in violation of Board Rule 217.11(1)(P). She is therefore subject to sanction under Code § 301.452(b)(13).

The ALJ determines that Respondent's violations, related to adequacy of care and sanctionable under Code § 301.452(b)(13), are most appropriately considered a Second Tier Offense under the Matrix because her actions meet the Matrix's definition of Second Tier conduct: "practice below standard with risk of patient harm."[9]

Applicable aggravating and mitigating circumstances can be found both within the Matrix and in Board Rule 213.33(c). An applicable aggravating factor is the tremendous risk of harm presented by a blood pressure level of 240. On the other hand, a mitigating circumstance is that

[9] 22 Tex. Admin. Code § 213.33(b).

Respondent's conduct was the result of her attempts to comply with the chain-of-command at the Facility. Respondent acknowledged that this was a learning experience. Additionally, Respondent does not have any prior history with the Board. Upon consideration of both the aggravating and mitigating factors, the ALJ determines that Respondent's violations are best characterized as a Second Tier Offense, Sanction Level I under the Matrix, which authorizes the Board to issue a warning or reprimand with stipulations including supervised practice, limited specific nursing activities, and/or a fine of $500 for each violation.

After considering the appropriate aggravating and mitigating factors, the ALJ recommends that the Board issue a warning and require Respondent to complete appropriate remedial education courses selected by the Board. The ALJ disagrees with Staff that sufficient aggravating factors exist to warrant stipulations requiring supervised practice.

V. FINDINGS OF FACT

1. Stella B. Egualkhide, a/k/a Stella B. Cunningham (Respondent) is a licensed vocational nurse (LVN) and holds license No. 227048, issued by the Texas Board of Nursing (Board).

2. In July 2018, Respondent was employed as a charge nurse and LVN at Silver Tree Nursing and Rehabilitation Center in Schertz, Texas.

3. On July 22, 2018, Respondent was working a shift as a medication aide rather than a charge nurse.

4. Respondent believed that in her role as a medication aide, she was not allowed to contact the physician and must comply the charge nurse's instructions.

5. A patient was scheduled to have her blood pressure medication, hydralazine, administered at 3:00 p.m.

6. When Respondent looked for the patient at 3:00 p.m., the patient was not in her room.

7. Respondent informed the Charge Nurse, who told her the patient was out with her family until dinner time.

8. Respondent saw the patient back in her room at 5:00 p.m. and took the patient's blood pressure reading of 177/72.

9. The physician's orders stated that the physician should be notified if the patient's blood pressure is greater than 150.

10. Respondent immediately informed the Charge Nurse of the patient's elevated blood pressure and advised the Charge Nurse to administer the blood pressure medication and inform the doctor for further intervention.

11. Respondent followed the Charge Nurse for approximately two hours, trying to get the Charge Nurse to administer medication and notify the physician.

12. The Charge Nurse became angry with Respondent and reiterated that she was the charge nurse that day.

13. At approximately 7:10 p.m., the patient's blood pressure reading was 240/118, and the Charge Nurse administered the blood pressure medication to the patient.

14. A blood pressure reading of 240/110 is dangerously high and presents serious risk of harm, including heart attack and stroke.

15. After Respondent told the Charge Nurse that Respondent would call the physician herself, the Charge Nurse called to notify the physician of the patient's condition.

16. Respondent does not have any prior history with the Board.

17. On June 17, 2020, the Board's staff (Staff) sent Respondent a First Amended Notice of Hearing.

18. The Notice of Hearing 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.

19. The hearing convened telephonically on August 3, 2020, before Administrative Law Judge (ALJ) Linda H. Brite. Attorney Helen Kelley represented Staff, and Respondent represented herself. On the same day, the hearing concluded and the record closed.

VI. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings 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. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

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

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

5. Respondent is subject to sanction under Texas Occupations Code § 301.452(b)(13) because she failed to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm, in that she: (1)failed to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal state, or local laws, rules or regulations affecting the nurse's current area of nursing practice; (2) failed to know the rationale and effects of medications and treatments and correctly administer them; (3) failed to institute appropriate nursing interventions that might be required to stabilize a patient's condition and/or prevent complications; and (4) failed to collaborate with the patient and members of the health care team in the interest of the patient's health care. 22 Tex. Admin. Code § 217.11(1)(A), (C), (M), (P).

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

7. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the mitigating and aggravating factors set forth in 22 Texas Administrative Code § 213.33(c) and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(b).

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue a warning and require Respondent to complete appropriate remedial education courses selected by the Board.

SIGNED September 28, 2020.

L Brite

LINDA H. BRITE
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: 512/305-7400 Fax: 512/305-7401 www.bon.texas.gov

Katherine A. Thomas, MN, RN, FAAN
Executive Director

October 13, 2020

The Honorable Linda H. Brite, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Via Electronic Filing

Re: In the Matter of Permanent Certificate No. LVN 227048
Issued to: **STELLA B. EGUALKHIDE**, a/k/a **STELLA B. CUNNINGHAM**
SOAH Docket No. **507-20-2122**

Dear Judge Brite:

Enclosed is ***Staff's Exceptions to the Proposal for Decision***.

Sincerely,

Helen Kelley

Helen Kelley
Assistant General Counsel

Electronically Signed as Authorized by
Tex. Bus. & Comm. Code §322.007

HK:cll
Enclosure

cc: Stella B. Egualkhide, via email: stellacunningham@rocketmail.com

SOAH DOCKET NO. **507-20-2122**

IN THE MATTER OF	§	BEFORE THE
PERMANENT CERTIFICATE	§	
NO. LVN 227048	§	STATE OFFICE
ISSUED TO	§	
STELLA B. EGUALKHIDE, a/k/a **STELLA B. CUNNINGHAM**	§	ADMINISTRATIVE HEARINGS

STAFF'S EXCEPTIONS TO PROPOSAL FOR DECISION

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and respectfully files its exceptions to the Proposal for Decision ("PFD") issued in this matter on September 28, 2020, as follows:

In this case the ALJ determined that "Respondent violated minimum standards of nursing practice" as alleged in Staff's formal charges. PFD at 1, Staff's Ex. 3 at 5. However, the ALJ opined that indirect supervision was not supported by the evidence. PFD at 1. Under section 2001.058(e)(1) of the Texas Occupations Code, Staff objects to the ALJ's recommended sanction and respectfully requests that the ALJ reconsider her recommended sanction.

Staff disagrees that Respondent's "attempts to comply with the chain-of-command at the Facility" is a "mitigating circumstance." PFD at 6-7. Attempting to "comply with the chain-of-command" is not listed in the matrix or the additional factors found in 22 Tex. Admin. Code 213.33(c)(1)-(18), nor should it be when it conflicts with a nurse's core "duty to evaluate the medical status of the ailing person seeking his or her professional care, and to institute appropriate nursing care to stabilize a patient's condition and prevent further complication of physical and mental harm." *Lunsford V. Board of Nurse Examiners,* 648 S.W.2d 391, 395 (Tex. App.—Austin 1983). While one might argue that attempting to "comply with the chair-of-command could" fall under "system dynamics in the practice setting" or a "matter that justice may require," Staff does

not believe it's logically consistent for Respondent's sanctionable conduct to also be considered mitigating. 22 Tex. Admin. Code 213.33(c)(12), (18). According to the ALJ's analysis of the case:

> It is uncontroverted that the patient's medication was not administered in accordance with the physician's orders. The physician's orders also required the physician to be notified if the blood pressure was above 150. At approximately 5:00 p.m., Respondent read the patient's blood pressure to be 177/72, which was an elevated blood pressure level that should have prompted notification of the physician. However, Respondent did not notify the physician. Instead, Respondent followed the Charge Nurse for approximately two hours, advising her to administer the medication and inform the physician.
>
> The record shows that Respondent believed she was not in a position to intervene or contact the physician because she was not the charge nurse that day. Despite her role as a medication aide that day, Respondent still held a responsibility to the patient to utilize her education and training as an LVN to stabilize the patient with elevated blood pressure in a timely manner. The preponderant evidence establishes that Respondent failed to appropriately intervene and notify the physician of the patient's condition.

PFD at 5-6. Accordingly, the ALJ rejected Respondent's excuse for failing to intervene and notify the physician of the patient's condition in determining that Respondent violated several subsections of Board Rule 217.11 and was subject to sanction under Section 301.452(b)(13) of the Texas Occupations code. PFD at 6. Consequently, to give any credence to Respondent's erroneous thinking, which lead to the dangerous situation this patient found herself in, would negate the deterrent effect the penalty imposed is intended to have. 22 Tex. Admin. Code § 213.33(c)(9).

Additionally, the ALJ cites Respondents lack of prior history with the Board as a mitigating factor, and given that Respondent was licensed in 2010 and the allegation occurred in 2018, Staff agrees that Respondent's lack of prior history, outside of this incident, during her decade long career as a nurse could be considered a mitigating factor. PFD at 7; Staff's Ex. 1 at 1, Staff's Ex. 3 at 5. However, Respondent's failure to intervene on behalf of the patient, despite her years of experience, could also be seen as aggravating, and evidence that a period of supervision is

necessary to remediate Respondent's practice and protect public safety while Respondent's knowledge deficits are filled in with continuing education courses.

Finally, Staff would argue that the aggravating factor of "tremendous risk of harm" to the patient vastly outweighs the other mitigating factors considered by the ALJ. PFD at 6. Respondent's acknowledgement "that 240/118 was a dangerously high blood pressure" shows that she knew this patient was in a precarious position, and yet despite that failed to intervene. PFD at 4. Rather than follow the Charge Nurse for hours, Respondent should have immediately followed the physician's order and notified the doctor of the patient's blood pressure reading. PFD at 5-6. Respondent's actions demonstrate a lack of critical thinking and lack of understanding of her duties as a nurse that are highly unlikely to be remediated by continuing education courses alone. A period of supervision as outlined by Ms. Laws would better serve Respondent and patients in the long run because it would reinforce what Respondent learns, hold her accountable for practicing in accordance with the Board's minimum standards for the period of supervision and deter future violations.

Respectfully submitted,

TEXAS BOARD OF NURSING

Helen Kelley

Helen Kelley, Assistant General Counsel
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Helen.Kelley@bon.texas.gov

STELLA B. EGUALKHIDE, a/k/a **STELLA B. CUNNINGHAM**
SOAH Docket No. **507-20-2122**

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing *Staff's Exceptions to Proposal for Decision* was provided by email on this, the 13th day of October 2020, to: Stella B. Egualkhide, via email: stellacunningham@rocketmail.com.

Helen Kelley

Helen Kelley, Assistant General Counsel

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

November 3, 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. 507-20-2122; Texas Board of Nursing v. Stella B. Egualkhide a/k/a Stella B. Cunningham

Dear Ms. Thomas:

On September 28, 2020, I issued the Proposal for Decision (PFD) in this case. The staff of the Texas Board of Nursing (Staff) timely filed exceptions on October 13, 2020. Stella B. Egualkhide a/k/a Stella B. Cunningham (Respondent) did not file any exceptions and did not respond to Staff's exceptions.

Staff's exceptions argue that Respondent's "attempt to comply with the chain-of-command at the Facility" is not a mitigating circumstance, because it is not listed in the matrix or additional factors in 22 Texas Administrative Code § 213.33(c)(1)-(18). Staff argues that because the ALJ rejected Respondent's excuses in determining that Respondent violated Board rules, Respondent's erroneous thinking should not be given credence as a mitigating factor.

The ALJ considered Respondent's attempt to comply with the chain-of-command to be a system dynamic in the practice setting and a matter that justice may require, under 22 Texas Administrative Code § 213.33(c)(12) and (18). The evidence established that Respondent's failures to intervene and notify the physician were caused by her desire to abide by the wishes of her supervising charge nurse that day. In other words, Respondent substituted the charge nurse's professional judgment for her own that day, when she certainly should not have. As such, the ALJ determined that remedial courses to develop Respondent's own critical thinking and judgment were more appropriate than requiring her to undergo indirect supervision for a year.

After considering Staff's Exceptions, the ALJ does not recommend any changes to the PFD and recommends that it be adopted as filed.

Sincerely,

L Brite

LINDA H. BRITE
Administrative Law Judge

LB/db
Enclosures

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

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Stella Egualkhide aka Stella Cunningham, 5806 Tranquil Dawn, San Antonio, TX, 78218– **VIA REGULAR MAIL**