DOCKET NUMBER 507-20-2653

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 830260, ISSUED TO SUSAN NICOLE DAMSKI	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: SUSAN NICOLE DAMSKI
C/O MARC M. MEYER, ATTORNEY
525 WOODLAND SQUARE BLVD.
STE 250
CONROE, TX 77384

SRINIVAS BEHARA
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; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling of October 26, 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. Respondent filed exceptions to the PFD on September 21, 2020. Staff filed a response to Respondent's exceptions to the PFD on October 6, 2020. On October 26, 2020, the ALJ filed his final letter ruling, in which he declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling of October 26, 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 that Formal Charges I, II, and IV were proven. For the conduct set forth in Formal Charge I, the ALJ found that the Respondent's conduct warrants a first tier, sanction level I sanction[1]. For the conduct set forth in Formal Charges II and IV, the ALJ found that the Respondent's conduct warrants a second tier, sanction level II sanction[2]. Where multiple violations of the Nursing Practice Act and/or Board rules are present in a single case, the most severe sanction recommended by the Board's Disciplinary Matrix for any one of the individual offenses must be considered[3]. The Board agrees with the ALJ that the Respondent's conduct collectively warrants a second tier, sanction II sanction, and that an Enforced Suspension is the most appropriate sanction in this case[4].

Respondent's conduct was serious in nature and placed a vulnerable patient at risk of harm[5]. Further, the Respondent's conduct is similar in nature to the conduct addressed in her prior 2017 TPAPN Board Order involving administration and wastage issues[6]. Repetition of these issues indicates the Respondent is not applying critical thinking, is carelessly failing to adhere to the minimum standards of nursing care, and is not recognizing necessary steps for patient safety[7]. The ALJ did not find any mitigating factors[8].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(6), that an Enforced Suspension is the most appropriate sanction in this matter.

The Respondent did not complete her 2017 TPAPN Board Order, thereby failing to remediate her prior deficiencies. In addition to the new violations, the Board is cognizant that Respondent's prior conduct must still be remediated. This is even more significant since Respondent's new violations are similar to the practice errors referenced in the 2017 TPAPN Board Order. Because the Respondent has committed new practice violations, the Board declines to enforce the suspension of the Respondent's license while she meets the requirements of the TPAPN program for one year. Instead, the Board

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[1] See pages 16-17 of the PFD.

[2] See page 17 of the PFD.

[3] Tex. Occ. Code §301.4531.

[4] See pages 17-18 and 21 of the PFD.

[5] See page 17 of the PFD.

[6] See pages 17-18 of the PFD.

[7] See *id.*

[8] See page17 of the PFD.

finds that the Respondent's license should be suspended until she can demonstrate twelve months of verifiable sobriety, to be followed by two years of probationary requirements and Board monitoring. The probationary requirements should include a nursing jurisprudence and ethics course, a documentation course, a medication administration course, and a critical thinking course[9]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board also agrees with the ALJ that the Respondent's practice should be indirectly supervised for the duration 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 during the pendency of the Order. 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. The Board also finds that the Respondent should 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. Finally, the Board finds that the Respondent should be subject to abstention and random drug testing requirements for the duration of the Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(6)[10] and are warranted by the nature of the new violations and the unfulfilled requirements of the prior Board Order.

IT IS THEREFORE ORDERED that Registered Nurse License Number 830260, previously issued to SUSAN NICOLE DAMSKI, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **ENFORCED** until RESPONDENT:

A. Obtains twelve (12) consecutive months of sobriety, which may be demonstrated by monthly urine drug screens consistent with the "DRUG AND ALCOHOL RELATED REQUIREMENTS" of this Order.

Any relapse prior to the completion of the required twelve (12) consecutive months of sobriety will result in revocation or, at a minimum, an extension of the enforced suspension until such twelve (12) consecutive months of sobriety and additional treatment have been attained.

IT IS FURTHER ORDERED, upon verification of successful completion of the above requirements, the Suspension will be **STAYED**, and RESPONDENT

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

[10] 22 Tex. Admin. Code §213.33(e)(6), which authorizes the probation of a license, either probated or enforced, to be followed by reasonable probationary stipulations that may include remedial education courses and practice for not less than two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings and random drug testing.

will be placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

B. 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.

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

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

E. 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. SUPERSEDING ORDER

IT IS FURTHER ORDERED that the sanction and conditions of this Order SHALL supersede all previous stipulations required by any Order entered by the Texas Board of Nursing.

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 suspension being stayed, 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. **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.

D. **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

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. **Indirect Supervision:** While under this Order, 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.

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

VI. DRUG AND ALCOHOL RELATED REQUIREMENTS

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

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

All random screens SHALL BE conducted through urinalysis. Any test result for a period of time in which the RESPONDENT is not working as a

nurse under the terms of this Order will not count towards satisfaction of this requirement. All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation/probation period.

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

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

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

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

may be considered the same as a positive result or refusal to submit to a drug or alcohol screen.

VII. 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.

VIII. 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 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. 507-20-2653 (September 4, 2020)

SOAH DOCKET NO. 507-20-2653

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
SUSAN NICOLE DAMSKI, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

In seven formal charges, the staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Susan Nicole Damski's (Respondent) Registered Nurse (RN) credential. Staff alleges that Respondent did not comply with some of the terms of an Agreed Order with the Board. Staff further alleges Respondent violated the Texas Nursing Practice Act and Board rules in May and June of 2018, while employed at CHI St. Luke's Medical Center (CHI) in Houston, Texas. The Administrative Law Judge (ALJ) concludes that Staff met its burden on some, but not all, allegations by a preponderance of the evidence and, for the reasons set forth herein, recommends a three-year, partially probated suspension of Respondent's license with stipulations.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

ALJ Srinivas Behara convened the hearing on July 23, 2020, using the Zoom videoconferencing platform through the State Office of Administrative Hearings (SOAH). Assistant General Counsel Helen Kelley represented Staff. Attorney Marc Meyer represented Respondent. The hearing concluded and the record closed the same day. Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

II. APPLICABLE LAW, STAFF'S ALLEGATIONS, AND PRIOR ORDER

A. Nursing Practice Act

The Texas Nursing Practice Act, found in chapter 301 of title 3, subtitle E of the Texas Occupations Code (Code), empowers the Board to discipline licensees, for, among other things,

violating a prior Board order (Code § 301.452(b)(1)); engaging in intemperate use of alcohol or drugs that the board determines endangers or could endanger a patient (Code § 301.452(b)(9)); engaging in unprofessional conduct (Code § 301.452(b)(10)); or failing to meet minimum standards of nursing practice (Code § 301.452(b)(13)). Staff asserts that Respondent's conduct is grounds for disciplinary action under the four Code provisions above, as well as pursuant to Board Rules 217.11 and 217.12, described below.[1]

B. Board Rules

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

- **Board Rule 217.11(1)(A) [Charges II, III, IV, V, and VI]**: Failing to know and conform to the Code and Board rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of practice;
- **Board Rule 217.11(1)(B) [Charges II, III, IV, V, and VI]**: Failing to implement measures to promote a safe environment for clients[2] and others;
- **Board Rule 217.11(1)(C) [Charges II, V, and VI]:** Failing to know the rationale for and the effects of medications and treatments and correctly administer the same;
- **Board Rule 217.11(1)(D)(ii) and (iv) [Charges II and V]**: Failing to accurately and completely report and document the nursing care rendered and administration of medications and treatments; [and]
- **Board Rule 217.11(3)(A) [Charge VI]**: Failing to utilize a systematic approach to provide individualized, goal-directed, nursing care.

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

- **Board Rule 217.12(1)(A) [Charges I-VI]**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice

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

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

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) [Charges II-VI]**: Failing to conform to generally accepted nursing standards in applicable practice settings;

- **Board Rule 217.12(1)(C) [Charges I and V]**: Improperly managing client records;

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

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

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

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

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

- **Board Rule 217.12(9) [Charge I]**: Dismissal from the Texas Peer Assistance Program for Nurses (TPAPN) for noncompliance;

- **Board Rule 217.12(10(A) [Charges I and VII]**: Using any controlled substance or any drug, prescribed or unprescribed, or device or alcoholic beverages while on duty or on call and to the extent that such use may impair the nurse's ability to safely conduct to the public the practice authorized by the nurse's license;

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

- **Board Rule 217.12(10)(C) [Charge III]**: Failing to follow the policy and procedure in place for the wastage of medications at the facility where the nurse was employed or working at the time of the incident(s);

- **Board Rule 217.12(10)(D) [Charges I and VII]**: Testing positive for a drug screen for which there is no lawful prescription; and

- **Board Rule 217.12(11)(B) [Charges I, III, VI, and VII]**: Violating an order of the Board, or carelessly or repetitively violating a state or federal law relating to the

practice of vocational, registered or advanced practice nursing, or violating a state or federal narcotics or controlled substance law.[3]

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

C. Prior Board Order

On January 29, 2013, the Board granted Respondent RN License Number 830260.[8] Since October 2, 2017, Respondent has been subject to a Confidential Agreed Order for Peer Assistance Program (Agreed Order), which was based on several incidents in 2015 and 2016.[9] In 2015, Respondent pleaded guilty and was convicted of Driving While Intoxicated, a Class B misdemeanor offense, committed on July 26, 2015. The next incidents occurred between October 9 and 31, 2015, while Respondent was employed with Memorial Hermann Memorial

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[3] In its First Amended Notice of Hearing, Staff cited to Board Rule 217.12(11)(B) and generally referenced chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code. However, the Controlled Substances Act contains multiple sections and Staff did not cite to any specific sections of the statute that Respondent allegedly violated. Furthermore, Staff did not cite to any specific sections of the Controlled Substances Act at the hearing. Texas Government Code 2001.052(a)(3) requires notice to include "a reference to the particular sections of the statutes and rules involved. Because of insufficient notice, the ALJ will not base any findings of violations in this case upon the Controlled Substances Act or Board Rule 217.12(11)(B), except for Charge I regarding alleged violation of the Agreed Order.

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

[5] Board Rule 213.33(b).

[6] Board Rule 213.33(c).

[7] 1 Tex. Admin. Code § 155.427.

[8] Staff Ex. 2.

[9] *See* Staff's First Amended Notice of Hearing.

City Medical Center (Memorial Hermann) in Houston, Texas. The Agreed Order states that Respondent removed medication from the medication dispensing system for patients but failed to document the administration of the medication in the patients' Medication Administration Records (MARs) and/or Nurses' Note. The Agreed Order further states that Respondent failed to follow Memorial Hermann's policy and procedure for the wastage of the unused portions of the medications. According to the Agreed Order, Respondent may have misappropriated the medications belonging to Memorial Hermann's facility and patients, or may have failed to take precautions to prevent such misappropriation. Finally, the Agreed Order states that on or about March 4, 2016, while employed at Houston Methodist Hospital in Sugar Land, Texas, Respondent violated Board rules regarding medication administration and wastage.

The Agreed Order required Respondent to enter into and comply with a TPAPN participation agreement[10] and complete a nursing and jurisprudence course. The Agreed Order did not provide a time period for when it would expire and did not specify a sanction level for the violations.

D. Alleged Violations

The allegations contained in Staff's seven formal charges are summarized as follows.

Charge I- In March 2018, Respondent fell out of compliance with her TPAPN participation agreement because she produced a urine specimen for a random drug screen that tested positive for lorazepam, and she did not timely present proof of a valid prescription for the medication.

Charges II-V - On the morning of May 14, 2018, while employed at CHI, Respondent withdrew one unit of oxycodone from the medication dispensing system for Patient 1. Respondent failed to take precautions to secure one 50 mg tablet of tramadol and one 5 mL unit of oxycodone belonging to Patient 1 in that she could not find the medications after an incident at CHI. Respondent failed to document and/or completely and accurately document the administration of the medication and/or failed to follow CHI's policy and procedure for wastage of the unused portions of medications. Later the same day, Respondent falsely documented in the MAR that she administered tramadol to Patient 1 when there was no record of withdrawal of tramadol from the medication dispensing system associated with the time and date of administration.

[10] Staff Ex. 8 at 3.

Charge VI - On or about May 26, 2018, while employed at CHI, Respondent withdrew 50 micrograms of fentanyl from the medication dispensing system for Patient 2 without a valid physician's order, and/or Respondent administered the medication after a supervising nurse informed Respondent the order was invalid.

Charge VII - On or about June 19, 2018, while employed at CHI, Respondent engaged in the intemperate and unlawful use of controlled substances when she produced a specimen for a reasonable-suspicion drug screen that tested positive for amphetamine and cocaine metabolites.

If the allegations are proven true, Staff seeks an enforced suspension of Respondent's license until Respondent presents proof of sobriety for one year, followed by a probation period with appropriate stipulations and remedial education requirements.

III. DISCUSSION

A. Summary of Evidence

Staff offered 19 exhibits, all of which were admitted at the hearing. Staff called as witnesses Respondent and Linda Laws, a Practice Consultant for the Board. Respondent testified on her own behalf and did not call any other witnesses or offer any exhibits. The following is a summary of the evidence based on Respondent's testimony and the documentary evidence:

1. Charge I: Non-compliance with TPAPN Participation Agreement

Respondent testified that that she was assaulted in late October 2017. She stated that she was later re-traumatized by the perpetrator's threatening behavior and stalking. On or about March 14, 2018, Respondent produced a urine specimen for a random drug screen to TPAPN that tested positive for lorazepam. Respondent was not working at the time, and she testified that she was not keeping track of some of her personal and professional responsibilities. Respondent stated that she was prescribed lorazepam in March 2018 for anxiety issues. She admitted she did not notify TPAPN of the prescription. Her TPAPN case manager, Roland Rodriguez, was not in the office at the time TPAPN received the positive test for lorazepam, and the covering case worker called Respondent about the positive test. After the call, Respondent uploaded to the TPAPN web portal her pharmacy's "Prescription History" printout, which provided the prescriber for

lorazepam, the prescription date, expiration date, and dosage.[11] Mr. Rodriguez returned to the office and called Respondent to inform her that the information she submitted was insufficient and TPAPN needed additional prescription information.[12] Respondent testified that Mr. Rodriguez also left her a voicemail to follow up the call and provided a deadline to submit the information, but she did not immediately respond.

On or about March 29, 2018, Respondent was dismissed from TPAPN and referred back to the Board. Respondent stated that she was unaware of her dismissal until she attempted to access the TPAPN web portal to provide additional prescription information and the portal indicated her account was suspended. Respondent testified that she called Mr. Rodriguez and left him a voicemail to discuss her status in TPAPN. Mr. Rodriguez sent a letter to Respondent on March 29, 2018, noting that Respondent's participation in TPAPN was closed and she had been referred to the Board.[13] Respondent asserted that her failure to timely provide the information was unintentional. She stated that she would like to participate in TPAPN and described the program as a blessing and gift.

2. Charges II-V: Non-compliance with Medication Rules

On May 14, 2018, Respondent was working the day shift at CHI's Thoracic Progressive Care Unit (PCU). She had been working at CHI for about one month. Respondent testified that patients were typically transferred to the PCU immediately after surgery. Patient 1 had a physician's order for 5 mg/5 mL oral suspension of oxycodone every four hours as needed for pain and 50 mg of tramadol every six hours.[14]

Respondent withdrew Patient 1's oxycodone at 7:43 a.m. and tramadol 11:05 a.m.[15] Respondent testified that the standard is for a nurse to administer medications within a one-hour

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[11] Staff Ex. 7 at 10.

[12] *See also* Staff Ex. 6 at 9.

[13] Staff Ex. 8 at 34.

[14] Staff Ex. 15 at 106. Oxycodone and tramadol are used to help alleviate moderate to severe pain.

[15] Staff Ex. 13 at 1.

window before or after the scheduled time for administration. Respondent stated that she placed the oxycodone vial and tramadol tablet in her pocket in anticipation of administering the medications to Patient 1. She testified that she then cleaned up Patient 1, who was able to move around and walk to the bathroom independently. According to Respondent, before she was able to administer the medications to Patient 1, the hospital issued a "Code Gray" security alert based on a combative patient in another room. Respondent stated that the Code Gray caused chaos on the floor, and she left Patient 1's room to assist with the combative patient.

Respondent testified that after the security issue was resolved, she realized Patient 1's medications were missing from her pocket. She immediately informed the charge nurse. Respondent stated that she and the charge nurse searched for the missing medications in the ICU hallway and Patient 1's room, but they were not found. Respondent stated that because she did not administer the medications, she did not document administration of tramadol or oxycodone to Patient 1 in the MAR. Respondent testified that a nurse would typically document wastage if a medication is dropped or lost. Respondent admitted she neither indicated wastage of the medications ~~and~~ nor indicated the medications were lost in the MAR or nurse's notes. Respondent testified that her preceptor nurse, Ernest Okeke, informed her to prepare a Pharmacy Variance Report.[16] In the Pharmacy Variance Report, Respondent documented the Code Gray as occurring at 1:40 p.m.[17] Respondent testified that she voluntarily offered to take a drug test, but she was not given one.

Later in the day around 6:00 p.m., Respondent administered tramadol to Patient 1.[18] Respondent admitted that there were no records showing that she withdrew tramadol for Patient 1. She testified that that although she could not recall with certainty, Mr. Okeke likely withdrew the tramadol for her to administer to Patient 1 because she was behind schedule on administering medications.

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[16] Staff Ex 9 at 1-2.

[17] Staff Ex. 1

[18] Staff Ex. 15 at 106.

3. Charge VI: Withdrawal of Medication without Physician's Orders

On May 19, 2018, Patient 2 had several surgeries at CHI, and Patient 2 was transferred from the Post Anesthesia Care Unit (PACU) to the PCU where Respondent worked that day.[19] Patient 2 had several "as needed" pain medications prescribed from the physician at the PACU, including fentanyl to be administered every hour for as-needed pain.[20] Respondent testified that fentanyl is a very potent opiate and used to alleviate severe pain. One nurse administered fentanyl to Patient 2 on May 19, 2018, for pain control issues.[21] Fentanyl was not administered to Patient 2 until a week later by Respondent.

Around 10:30 a.m. on May 26, 2018, Respondent withdrew 50 micrograms of fentanyl.[22] Either before or after the withdrawal, Respondent accompanied Mr. Okeke for hospital rounds. Respondent testified that she and Mr. Okeke had a conversation about Patient 2's pain management. According to Respondent, Mr. Okeke told her to administer morphine to Patient 2 if Patient 2 was in pain, but they did not discuss fentanyl. Later that afternoon around 4:10 p.m., Respondent administered morphine to Patient 2.[23] Respondent testified that she again attended to Patient 2 towards the end of her shift when Patient 2 indicated she was in an excruciating amount of pain based on removal of a nerve blocker or drainage tube. Respondent considered Patient 2's severe stress and thought fentanyl was appropriate, given that other vital signs were stable. Around 6:55 p.m., Respondent administered 25 micrograms of fentanyl to Patient 2 intravenously, and she documented wasting the remaining 25 micrograms.[24] Respondent testified that she reassessed Patient 2's response to the fentanyl and documented it as positive in the Nurse's Notes.

Respondent noted that around the time when her shift was ending at 7:00 p.m., she had a conversation with the transition nurse and Mr. Okeke. Respondent testified Mr. Okeke informed

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[19] *See* Staff Ex. 16 at 1.

[20] Staff Ex. 16 at 5, 13.

[21] Staff Ex. 16 at 5.

[22] Staff Ex. 14 at 1.

[23] Staff Ex. 16 at 76.

[24] Staff Ex. 16 at 79; Staff Ex. 14 at 1.

her that nurses in the PCU should not administer medications ordered in the PACU, and she should not have administered fentanyl to Patient 2. Respondent stated that she was frustrated with the situation because she was not previously informed that a PACU order was automatically discontinued upon transfer. She felt it was a system failure. Respondent stated that she called the surgeon on call, informing him that Patient 2's fentanyl order was still active and she had administered it. According to Respondent, she requested that the surgeon discontinue the order so the mistake would not be made again by anyone else. Respondent testified that she was never provided any written policy or documentation informing her that PACU orders should not be followed at the PCU.[25]

The following day on May 27, 2018, Mr. Okeke wrote an email to CHI's Director of Nursing, Greg Lomasang. Mr. Okeke reported to Mr. Lomasang in the email that he informed Respondent at 10:00 a.m. on May 27, 2018, that fentanyl should not be used for Patient 2, but Respondent administered it anyway without his knowledge.[26] In the email, Mr. Okeke requested a meeting with Mr. Lomasang to discuss the issue. Respondent testified that Mr. Lomasang eventually spoke with her individually about the fentanyl order, but only after Respondent brought up concerns about the order to an assistant nursing director. At the hearing, Respondent could not identify in the medical records whether any other nurses administered fentanyl to Patient 2 after May 26, 2018. The medical records show two different nurses administered 50 micrograms of fentanyl to Patient 2 on May 28, 2018, and May 29, 2018, respectively.[27]

4. Charge VII: Substance Abuse

On June 19, 2018, Respondent wrote a Pharmacy Variance Report for wasted morphine.[28] She offered to provide a drug screen, and she then finished her charting. She testified that her supervisor took her to employee health services for a drug screening, and she provided samples of

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[25] Staff later referenced Exhibit 10, titled "Transfer of Patient Within the Hospital," through the testimony of its expert witness, Ms. Laws. Page 2 of the policy states that "Orders must be re-entered in the Electronic Medical Record (EMR) with a change in level of care[,]" and "[a]ll previous orders are discontinued except for . . . Orders specified to be continued by the primary or managing consulting physician or service designee."

[26] Staff Ex. 9 at 3.

[27] Staff Ex. 16 at 94.

[28] Staff Ex. 9 at 4.

blood, breath, and urine.[29] Respondent was informed by CHI's human resources that she tested positive for an amphetamine and cocaine metabolite.[30] Respondent testified that she understood there is typically a split specimen taken so that a backup specimen can be tested again. She requested a retest from CHI and offered to provide, at her own expense, a hair analysis and fingernail analysis. Respondent stated that CHI would not accept her offer, and she was formally terminated on July 6, 2018.[31]

Respondent asserted that she did not use cocaine and there was no way for her to have accidentally absorbed it. Respondent further testified that in June 2018, she was participating in a pre-trial diversion program after being arrested for suspicion of driving while intoxicated. As a result, according to Respondent, she was required to take random urine tests at least once a month. Respondent stated that the test covered at least 10 drug classes, including cocaine. Respondent testified that she never violated any of the pre-trial drug testing requirements, and she asserted she would have been dismissed from the pre-trial diversion program had she tested positive for cocaine. The Fort Bend County case was moved into probationary status in late 2019. Respondent testified that she continued to provide random urine samples at least once a month and never had a positive result.

B. Ms. Laws' Testimony on Sanction Level

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

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[29] Staff's Exhibit 17 was admitted for the limited purpose of proving that a specimen was given but the ALJ ruled that no weight would be given to the results without any expert testimony, which was not timely offered by Staff.

[30] At the hearing, Staff noted that it was not seeking to discipline Respondent for the positive screen of amphetamine because she had a valid prescription for an ADHD medication, which would excuse the positive test.

[31] Staff Ex. 12.

Ms. Laws testified that because Respondent's conduct was not an isolated failure to comply with the TPAPN requirements, she would classify the alleged violation in Charge I to fall under the Second Tier, Sanction Level 1 of Code § 301.452(b)(1). Ms. Laws emphasized that, under the Matrix, a Board order may be subject to next higher sanction and an extension of the stipulations in the Agreed Order. In her opinion, based on the findings in the Agreed Order and the violation of her TPAPN participation agreement, Respondent's case should result in an enforced suspension until Respondent obtained the appropriate level of sobriety. Then Respondent could enter into probation with stipulations.

Regarding the alleged violation of Code § 301.452(b)(9), Ms. Laws opined that Respondent's conduct involved patient care so the violation would not be classified as a First Tier violation. Ms. Laws opined that Respondent's positive drug test for cocaine indicated misuse of drugs with a risk of patient harm, making it a Third Tier, Sanction Level II violation. Ms. Laws testified that the patients on the PCU floor were vulnerable, often recovering from multiple surgeries, and were likely suffering from a significant amount of pain. Ms. Laws stated that, considering these aggravating factors, the appropriate sanction would involve an enforced suspension of Respondent's license with appropriate TPAPN stipulations to demonstrate sobriety, and remedial education.

As to Code § 301.452(b)(10), Ms. Laws testified that all nurses are required to know state, federal, and other applicable agency rules, including the Texas State Board of Pharmacy rules, which require a nurse to understand the accurate counting of narcotics. Ms. Laws stated that Respondent's conduct demonstrated she did not follow basic standards of professional nursing practice. She opined that the violations stated in Staff's Formal Charges II through V would fall under the Third Tier, Sanction Level I of the Matrix for a violation of Code § 301.452(b)(13). She testified that a Variance Report is appropriate for risk management purposes to inform management and administration of an occurrence, but a nurse is required by law to document wastage of medication in the patient's records so that it becomes part of the patient's history. Ms. Laws considered as an aggravating factor Respondent's prior Agreed Order, which specified violations for documentation, wastage, and the failure to secure medications. Ms. Laws testified that, based on both Respondent's history and significant level of nursing experience, Respondent

should have known that she was required to document wastage in the patient's records. Yet she did not follow through on the critical task.

Finally, Ms. Laws testified that several other aggravating circumstances existed, including the number of events, multiple medication issues, multiple documentation issues, prior complaints and disciplinary history for similar conduct, and patient vulnerability. Ms. Laws opined that there was a significant risk of harm when patients, particularly surgical patients, do not get medication. Based on the lack of proof of any mitigating factors and the existence of several aggravating circumstances, Ms. Laws recommended an enforced suspension of Respondent's license with various stipulations, including courses in nursing jurisprudence and ethics, medication administration, documentation, and critical thinking. Ms. Laws did not recommend a fine. She stated that Respondent should be required to restart her participation in TPAPN. She noted that TPAPN would be able to provide the appropriate requirements and terms for Respondent's drug testing and cognitive and behavior therapy.

C. Analysis - Violations

As described below, Staff met its burden to prove the violations alleged in Charges I, III, and IV, but not the other charges.

Charge I

The evidence was undisputed that Respondent did not comply with her TPAPN participation agreement when Respondent did not disclose that she was taking lorazepam prior to her drug screening. Respondent also admitted that she failed to timely respond to her TPAPN case manager. TPAPN appropriately closed her participation in the program and referred her to the Board. Respondent did not offer a valid excuse for her failure to respond. Accordingly, Staff met its burden to prove that Respondent violated her Agreed Order, which is a violation of Code § 301.452(b)(1) and Board Rules 217.12(9), (11)(B).

On the other hand, Staff did not argue or present any evidence that Respondent's lorazepam prescription related to or caused any patient endangerment in violation of Code § 301.452(b)(9).

The credible evidence demonstrated that Respondent took the medication to address significant trauma in her life. In addition, there was no evidence that Respondent's violation of her TPAPN agreement involved unprofessional conduct likely to deceive, defraud, or injure a patient or the public under Code § 301.452(b)(10), or the related provisions of Board Rule 217.12, as charged by Staff.

Charges II – V

The evidence demonstrated that on May 14, 2018, Respondent failed to take precautions to secure Patient 1's medications (oxycodone and tramadol) as alleged in Charge IV. Respondent's explanation of her inability to locate the medications due to the Code Gray was difficult to credit. Respondent withdrew oxycodone and tramadol around 7:45 a.m. and 11:05 a.m., respectively. She then recorded in the Pharmacy Variance Report that the Code Gray occurred several hours later around 1:40 p.m. Respondent could not explain why she did not administer the medications during the large gap in time between withdrawal and the Code Gray. In addition, assuming Respondent placed the medications in her pocket(s) because of the Code Gray, she did not offer any reasonable explanation of why or how the medications could have fallen out of her pocket(s).

Because Respondent did not administer the lost oxycodone to Patient 1, it would have been inappropriate to record administration in the MAR. Therefore, the evidence did not support Charge II's allegation that Respondent failed to document or accurately document the administration of oxycodone. It was undisputed, however, that she did not document wastage of the medications in Patient 1's medical records, as required by minimum standards of nursing. Respondent's explanation that her coworkers at CHI instructed her to fill out a Pharmacy Variance Report did not excuse her responsibility to completely and accurately reflect wastage in Patient 1's medical records. Accordingly, Staff proved the violations alleged in Charge III.

In Charge V, Staff alleged that on May 24, 2018, Respondent also falsely documented in the MAR that she administered tramadol to Patient 1 at 6:00 p.m. In support, Staff submitted evidence that there were no records of medication withdrawals from the medication dispensing system associated with that time and date. Respondent did not dispute that Staff's Exhibit 13 (the medication dispensing system information) did not reflect her withdrawal of tramadol associated

with the 6:00 p.m. administration. Rather, Respondent pointed out that Exhibit 13 only reflects Respondent's withdrawals for Patient 1. Exhibit 13 does not show whether any other nurses withdrew medications that day for Patient 1. Respondent offered a plausible explanation that her preceptor nurse, Mr. Okeke, likely withdrew the medication for Respondent, and his withdrawal would not show up on Respondent's system information. Mr. Okeke was not called as a witness, and Staff did not provide any evidence of Mr. Okeke's medication withdrawals that day to confirm or deny Respondent's assertion. Because there was an open question whether someone other than Respondent withdrew tramadol for Patient 1 for the time period in question, Staff did not meet its burden of proof to show that Respondent did not administer the medication as alleged in Charge V.

As described above, Staff proved by a preponderance of the evidence that Respondent engaged in the conduct as alleged in Charges III and IV, and the conduct violated Code § 301.452(b)(10) and (b)(13). Staff also proved that Respondent's conduct, as alleged in Charges III and IV, violated Board Rules 217.11(1)(A) and (1)(B), and Board Rules 217.12(1)(A), (1)(B), (4), and (10)(C).

Charge VI

Staff alleged that on May 26, 2018, Respondent withdrew fentanyl from the medication dispensing system for Patient 2 without a valid physician's order, and/or she administered fentanyl to Patient 2 after she was told the order was invalid. Mr. Okeke was not called as a witness. However, his email indicated to CHI's Director of Nursing that he informed Respondent that fentanyl should not be used for Patient 2 on the morning of *May 27*, 2018. Accordingly, there was no evidence that Respondent was instructed not to administer fentanyl to Patient 2 the day prior on *May 26*, 2018. Staff also introduced CHI's Policy and Procedure regarding the automatic discontinuation of medications when a patient is transferred from a different level of care. On the other hand, the records indicated that the policy was not followed by CHI. The order for fentanyl remained active before and after Respondent administered fentanyl to Patient 2. Patient 2's medical records showed that two different nurses had administered 50 micrograms of fentanyl to Patient 2 on May 28, 2018, and May 29, 2018, respectively. Therefore, Staff did not meet its burden of proof on Charge VI.

Charge VII

Respondent did not dispute that she was informed her June 19, 2018 drug screen resulted in a positive finding for cocaine metabolites. However, she disputed the accuracy of the results and denied ever using cocaine. Staff did not timely offer a witness to explain the results of the drug screen (Staff's Exhibit 17). There was no evidence in support of the facility's testing protocol to establish reliability and validity of the testing procedures and results. In addition, as with any scientific test, the interpretation of a drug test requires balancing a number of factors, including the amount and purity of the specimen, the physical characteristics of the individual being tested, and the nature and length of the individual's drug usage. Without the supporting information, the ALJ cannot make an accurate interpretation and assessment of the raw data provided in Staff's Exhibit 17 and cannot give any significant weight to the CHI drug screening. Furthermore, Respondent credibly testified that she was participating in a criminal pre-trial diversion program, which required her to be drug-tested during the same time period. According to Respondent, she never had a positive test for cocaine through that program. Accordingly, Staff failed to meet its burden that Respondent engaged in the intemperate and unlawful use of cocaine as alleged in Charge VII.

D. Analysis - Sanctions

Staff sufficiently proved a number of violations by Respondent, thereby warranting the imposition of sanctions against her. Within each tier, the Matrix sets forth sanction levels I and II that are determined by reference to aggravating and mitigating factors. In addition, Board Rule 213.33(c) provides a list of factors that the Board and SOAH shall consider in conjunction with the Matrix. While the ALJ may recommend a sanction, the Board remains the ultimate arbiter of the disciplinary action taken in this case.[32]

As to Charge I, Staff argued that Respondent's violation of Code § 301.452(b)(1) was appropriately classified as a Second Tier, Sanction Level II offense under the Matrix, which would warrant suspension or revocation. Respondent's failure to comply with her TPAPN participation

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

agreement, however, demonstrated a failure to comply with a technical, non-remedial requirement in a prior Board order or stipulation, similar to a missing employer report. The Agreed Order also did not provide a sanction level, so there is no framework for determining the "next higher administrative sanction." Although Respondent failed to report a prescription to her TPAPN case manager as required by the TPAPN agreement, there was no dispute that Respondent had a valid prescription for lorazepam related to her trauma and anxiety. Because there was also no allegation or evidence of alcohol or drug misuse as it relates to Respondent's lorazepam prescription, Respondent's violation should be classified as First Tier, Sanction Level I under Code § 301.452(b)(1). Pursuant to the Matrix, Sanction Level I would require Respondent's full compliance with and continuation of her Agreed Order. Staff did not request a fine and no fine is recommended.

Staff also proved the conduct alleged in Charges II and IV, which violated Code § 301.452(b)(10) and (b)(13) and numerous Board rules. Whether Respondent's conduct is analyzed under Code § 301.452(b)(10) as unprofessional conduct or failure to conform to minimum standards of acceptable nursing practice pursuant to Code § 301.452(b)(13), this case meets the Second Tier, Sanction Level II classification under both sections of the Matrix. The First Tier is inappropriate under either Code provision because Respondent's conduct did not involve an isolated instance of unprofessional conduct, and her conduct involved more than low risk to patients. Applying the aggravating and mitigating factors listed in the Matrix and Board Rule 213.33(c)(1)-(18), the number of violations and Respondent's prior Board disciplinary history are aggravating circumstances. Respondent did not submit any credible evidence of mitigating factors. As Ms. Laws testified, Patient 1 was a vulnerable patient recovering from surgery and very likely needed pain medications to heal appropriately. Given that the Code Gray, according to Respondent, occurred several hours after she withdrew the oxycodone and tramadol, there was no reason for her to have not already administered the medications to Patient 1, or for her to lose the medications. Respondent's misplacement of the controlled substances, and her failure to document the loss of medications, were serious and could have affected the patient's ongoing treatment.

In addition, the Agreed Order detailed similar instances involving administration and wastage issues of controlled substances. Respondent's repetition of these violations indicates

Respondent is not applying critical thinking, carelessly failing to adhere to minimum standards of nursing care, and not recognizing necessary steps for patient safety. Because the primary objective of a sanction is to ensure the protection of the public, the appropriate sanction for the offenses is Second Tier, Level II. Therefore, the ALJ recommends a three-year, partially probated suspension of Respondent's RN license as follows: (1) an enforced suspension of Respondent's license until she has shown her sobriety and compliance with the requirements of Texas Peer Assistance Program for Nurses (TPAPN) for one year; (2) a probated suspension of Respondent's license with indirect supervision requirements; (3) completion of courses in medication administration, documentation, critical thinking, and nursing jurisprudence and ethics; and (4) any other stipulations the Board deems appropriate. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. The Texas Board of Nursing (Board) issued Susan Nicole Damski (Respondent) a Registered Nurse (RN) License, No. 830260, in January 2013.

2. On October 2, 2017, Respondent and the Board entered into a Confidential Agreed Order for Peer Assistance Program (Agreed Order).

3. The Agreed Order was based on several incidents in 2015 and 2016, including: a Driving While Intoxicated misdemeanor conviction; medication administration and wastage issues from October 9, 2015 through October 31, 2015, when Respondent was employed with Memorial Hermann Memorial City Medical Center in Houston, Texas; and medication administration and wastage issues on May 4, 2016, when Respondent was employed at Houston Methodist Hospital in Sugar Land, Texas. The Agreed Order required Respondent to execute and comply with a Texas Peer Assistance Program (TPAPN) participation agreement and complete a nursing and jurisprudence course. The Agreed Order did not provide a time period when it would expire or a sanction level for the violations.

4. In March 2018, Respondent fell out of compliance with her TPAPN participation agreement because she produced a urine specimen for a random drug screen that tested positive for lorazepam. Respondent was prescribed lorazepam for anxiety issues relating to trauma, but she did not timely present adequate proof of a valid prescription for the medication to TPAPN. TPAPN closed her participation with the program and referred her to the Board.

5. On May 14, 2018, Respondent was working the day shift at the Thoracic Progressive Care Unit (PCU) of CHI St. Luke's Medical Center (CHI) in Houston, Texas. Patient 1 was transferred to the PCU immediately after a surgery.

6. Patient 1 had a physician's order for 5 mg/5 mL oral suspension of oxycodone every four hours as needed for pain and 50 mg of tramadol every six hours.

7. On the morning of May 14, 2018, while employed at CHI, Respondent withdrew one unit of oxycodone and one unit of tramadol from the medication dispensing system for Patient 1.

8. Respondent failed to take precautions to secure Patient 1's oxycodone and tramadol in that she lost the medications without a valid excuse.

9. Respondent prepared Pharmacy Variance Reports to indicate she lost Patient 1's medications, but failed to follow CHI's policy and procedure to document wastage of Patient 1's unused oxycodone and tramadol in the MAR and/or Nurse's Notes.

10. Respondent's loss of Patient's 1 medications was serious and similar to prior incidents involving Respondent as described in the Agreed Order.

11. Respondent did not administer oxycodone to Patient 1, so she was not required to record that she administered the medication to Patient in in the Medical Administration Record (MAR).

12. On May 26, 2018, Respondent withdrew fentanyl from the medication dispensing system for Patient 2 and administered it to Patient 2.

13. Patient 2's medical records showed that different PCU nurses had administered fentanyl to Patient 2 before and after Respondent administered fentanyl to Patient 2, indicating that CHI did not enforce its policy requiring discontinuation of medication orders when a patient had a change in level of care.

14. The evidence was insufficient to demonstrate that Respondent used cocaine.

15. In June 2018, Respondent was participating in a pre-trial diversion program, and she was required to take random urine tests at least once a month, which tested for cocaine. Respondent did not violate any of the pre-trial drug testing requirements, and she continued to provide random urine samples at least once a month and did not have a positive result for cocaine.

16. On February 14, 2020, staff of the Board (Staff) filed formal charges against Respondent and docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas, for assignment of an Administrative Law Judge (ALJ).

17. On July 11, 2020, Staff sent Respondent an Amended Notice of Hearing and Formal Charges. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

18. ALJ Srinivas Behara convened the hearing on July 23, 2020, using the Zoom videoconferencing platform through SOAH. Assistant General Counsel Helen Kelley represented Staff. Attorney Marc Meyer represented Respondent. The hearing concluded and the record closed the same day.

V. CONCLUSIONS OF LAW

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

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

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

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

5. Respondent is subject to sanction for her dismissal from TPAPN for noncompliance and referral by TPAPN to the Board. Code § 301.452(b)(1); 22 Tex. Admin. Code § 217.12(9), (11)(B).

6. Respondent's failures to take precautions to secure Patient 1's medications and to document wastage of Patient 1's medications are subject to sanction as unprofessional conduct that was likely to deceive, defraud, or injure a patient or the public. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (1)(B), (4), (10)(C).

7. Respondent's failures to take precautions to secure Patient 1's medications and to document wastage of Patient 1's medications are subject to sanction as a failure to meet minimum standards of nursing practice. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(A), (1)(B).

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

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

VI. RECOMMENDATION

The ALJ recommends that the Board sanction Respondent by issuing a three-year, partially probated suspension of Respondent's RN license as follows: (1) an enforced suspension of Respondent's license until she has shown her sobriety and compliance with the requirements of Texas Peer Assistance Program for Nurses (TPAPN) for one year; (2) a probated suspension of Respondent's license with indirect supervision requirements; (3) completion of courses in medication administration, documentation, critical thinking, and nursing jurisprudence and ethics; and (4) any other stipulations the Board deems appropriate.

SIGNED September 4, 2020.

SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

DOCKET NO. 507-20-2653

IN THE MATTER OF	§	
PERMANENT CERTIFICATE	§	BEFORE THE TEXAS STATE
NUMBER RN 830260	§	
ISSUED TO SUSAN NICOLE DAMSKI,	§	OFFICE OF ADMINISTRATIVE HEARINGS
RESPONDENT	§	

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Susan Nicole Damski, through her attorney, to file these Exceptions to the Proposal for Decision.

EXCEPTIONS

Findings of Fact Nos. Seven (7) – Eleven (11): Respondent excepts to Findings of Fact Nos. Seven (7) – Eleven (11) because it is not supported by the evidence. Specifically, Respondent notes that Formal Charges II & III relate to a withdrawal of oxycodone from the pyxis at 0743 on May 14th, 2018.[1] Respondent admitted that she failed to document the administration of this medication shortly after this time as there is no documentation of the medication administration at this time.[2] However, Respondent notes that the medication withdrawn matches the order as written, and therefore there would be no waste. Based on this, Respondent argues that findings of fact should be written in part to replace Findings of Fact Nos. Seven (7) – Eleven (11) as follows:

- At 0743 on May 14, 2018, Respondent withdrew 5 mg of oxycodone and administered the medication to Patient 1;
- Respondent failed to document the administration of oxycodone to Patient 1 at or shortly after 0743 on May 14, 2018;
- Respondent was not required to document wastage of the oxycodone withdrawn at 0743 on May 14, 2018 because the medication was administered to Patient 1.

[1] Staff's Exhibit 13, at 1.

[2] Staff's Exhibit 15, at 106. Respondent notes that this is where the administration of the oxycodone should have been documented.

The Respondent argues that the Tramadol withdrawn at 1105[3] and the oxycodone withdrawn at 1106[4] are the medications that were at issue in Formal Charge IV. It was those medication that the Respondent asserts were lost after the Code Gray, not the oxycodone withdrawn at 0743. When Respondent became aware that the medications were missing, she consulted with her preceptor, Ernest Okeke, and filled out the medication variance report per his instructions.[5] Respondent notes that there is also not documentation of administration of either medication between the time the medications were withdrawn and the documentation of the pharmacy variance report.[6] Respondent notes that she was following the directions of her preceptor and the pharmacy in documenting the variance without documenting wastage, and that her actions were within her understanding of the policy of CHI St. Luke's Medical Center. Respondent also argues that her testimony indicated that she was in Patient 1's room after withdrawing the medications and that she had just completed assisting Patient 1 with cleaning up after going to the bathroom, but that the Code Gray was called immediately after she had completed cleaning Patient 1 up, but before she could administer the medications to Patient 1. In addition, the time lag until she filled out the medication variance report is reasonable given that she had to notify her preceptor, discuss the situation with him, and search Patient 1's room before she filed the medication variance report. Based on this, Respondent argues that findings of fact should be written in part to replace Findings of Fact Nos. Seven (7) – Eleven (11) as follows:

- Approximately 1340 on May 14, 2018, and at the direction of her preceptor, Ernes Okeke, Respondent prepared Pharmacy Variance Reports to document that she lost Patient 1's tramadol withdrawn at 1105 and oxycodone withdrawn at 1106 and lost during a Code Gray at CHI.

Conclusions of Law Nos. Six (6) and Seven (7): Based on the foregoing arguments regarding Findings of Fact Nos. Seven (7) – Eleven (11), Respondent excepts to Conclusions of Law Nos.

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[3] Staff's Exhibit 13, at 1.

[4] *Id.*

[5] Staff's Exhibit 9, at 1 – 2.

[6] Staff's Exhibit 15, at 106. Respondent notes that administration of Tramadol was documents at 1408 on May 14, 2018. *Id.* This corresponds to the Respondent withdrawing another Tramadol at 1406. Staff's Exhibit 13, at 1.

Six (6) and Seven (7). Specifically, Respondent asserts that these Conclusions of Law should be rewritten as follows:

- Respondent's failure to document the administration of oxycodone to Patient 1 at or shortly after 0743 on May 14th, 2018 are subject to sanction as a failure to meet minimum standards of nursing practice. Code § 301.452(b)(13); 22 Texas Admin Code § 217.11(1)(D);
- Respondent's failure to document the administration of oxycodone to Patient 1 at or shortly after 0743 on May 14th, 2018 are subject to sanction as unprofessional conduct. Code § 301.452(b)(10); 22 Texas Admin Code § 217.12(1)(A), (1)(C);

Recommended Sanction: The Respondent excepts to the Sanction Recommendation asserted by the Administrative Law Judge in that a sanction of a one-year enforced suspension followed by a three year probated suspension is excessive and does not take into account the mitigating evidence presented by the Respondent.

First, the Respondent notes Finding of Fact No. Fifteen notes that:

> In June 2018, Respondent was participating in a pre-trial diversion program, and she was required to take random urine tests at least once a month, which tested for cocaine. Respondent did not violate any of the pre-trial drug testing requirements, and she continued to provide random urine samples at least once a month and did not have a positive result for cocaine.

Respondent further testified that she continues to be on probation for the offense of driving while intoxicated and is regularly tested for drugs and alcohol. Respondent testified that she has not had a positive test while on probation. Further, Respondent noted that any violation of those terms of probation would have landed her in jail.

Second, Respondent notes that based on the discussion and arguments above, the violations for which there is evidence, and that she has admitted, relate to a failure to document medication administration rather than any alleged diversion of medications. And the Respondent notes that even the positive tests for her prescription medications were not for opioid narcotic medications such as oxycodone or tramadol.

Finally, Respondent notes that the Administrative Law Judge rightfully noted that her dismissal from the TPAPN program was the result of a "technical, non-remedial requirement",[7] and not a substantive violation such as a positive drug test for a medication for which she did not

[7] Proposal for Decision, at 17.

have a valid prescription. Taken together, these three arguments show that an enforced suspension is an excessive disciplinary action, especially since Respondent has had almost two years of continuing drug and alcohol testing after her dismissal from the TPAPN program. As the Administrative Law Judges notes, Respondent's prior agreed order, which was a confidential order to complete TPAPN, did not provide a sanction level.[8] Based on this, Respondent argues that a two-year reprimand with indirect supervision requirements, completion of certain remedial education courses as designated by the Board, and the standard Board of Nursing drug testing regime is proper to ensure protection of the public and remediate Respondent's practice as a nurse.

PRAYER FOR RELIEF

Respondent, Susan Nicole Damski prays that the honorable Administrative Law Judge:

1. Strike Findings of Fact Nos. Seven (7) – Eleven (11) and replace them with the following Findings of Fact;

    a. At 0743 on May 14, 2018, Respondent withdrew 5 mg of oxycodone and administered the medication to Patient 1;

    b. Respondent failed to document the administration of oxycodone to Patient 1 at or shortly after 0743 on May 14, 2018;

    c. Respondent was not required to document wastage of the oxycodone withdrawn at 0743 on May 14, 2018 because the medication was administered to Patient 1;

    d. Approximately 1340 on May 14, 2018, and at the direction of her preceptor, Ernes Okeke, Respondent prepared Pharmacy Variance Reports to document that she lost Patient 1's tramadol withdrawn at 1105 and oxycodone withdrawn at 1106 and lost during a Code Gray at CHI.

2. Replace Conclusions of Law Nos. Six (6) and Seven (7) with the following conclusions of law:

    a. Respondent's failure to document the administration of oxycodone to Patient 1 at or shortly after 0743 on May 14th, 2018 are subject to sanction as a failure to meet minimum standards of nursing practice. Code § 301.452(b)(13); 22 Texas Admin Code § 217.11(1)(D);

    b. Respondent's failure to document the administration of oxycodone to Patient 1 at

[8] *Id.*

or shortly after 0743 on May 14th, 2018 are subject to sanction as unprofessional conduct. Code § 301.452(b)(10); 22 Texas Admin Code § 217.12(1)(D);

3. Change the Sanction Recommendation to a Reprimand for two years, indirect supervision, remedial education courses to be determined by the Board of Nursing, and the Board of Nursing's standard drug and alcohol testing regime; AND

4. Propose to the Texas Board of Nursing in a Decision all relief at law or in equity to which Respondent is entitled.

Respectfully submitted,

By: Marc M Meyer

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CERTIFICATE OF SERVICE

This is to certify that on the 21st day of September, 2020, a true and correct copy of the above and foregoing document was served on the following individual(s) at the location(s) and in the manner indicated below:

Docketing Division
State Office of Administrative Hearings
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300 W. 15th Street, Suite 504
Austin, TX 78701-1649
VIA Texas electronic filing portal

Helen Kelley, Assistant General Counsel
Texas Board of Nursing
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Katherine A. Thomas, MN, RN, FAAN
Executive Director

October 6, 2020

The Honorable Srinivas Behara, Administrative Law Judge — via electronic filing
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Re: In the Matter of Permanent Certificate No. RN 830260
Issued to: **SUSAN NICOLE DAMSKI**
SOAH Docket No. **507-20-2653**

Dear Judge Behara:

Enclosed is ***Staff's Response to Respondent's Exceptions to Proposal for Decision*** in the above-referenced matter.

Sincerely,

Helen Kelley

Helen Kelley
Assistant General Counsel

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

HK/cll
Enclosure

cc: Marc M. Meyer, Attorney, via email: marc@marcmeyerlawfirm.com

SOAH DOCKET NO. 507-20-2653

IN THE MATTER OF	§	BEFORE THE
PERMANENT CERTIFICATE	§	
NO. RN 830260	§	STATE OFFICE
ISSUED TO	§	
SUSAN NICOLE DAMSKI	§	ADMINISTRATIVE HEARINGS

STAFF'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO PROPOSAL FOR DECISION

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and submits its *Staff's Response to Respondent's Exceptions to Proposal for Decision* ("PFD") in the above-referenced matter as follows:

While Respondent objects to Findings of Fact Nos. 7 through 11 because they are "not supported by the evidence," Staff would argue that there is no evidence to support her proposed changes that "[a]t 0743 on May 14, 2018, Respondent withdrew 5 mg of oxycodone *and administered the medication to Patient 1*" and "Respondent was not required to document wastage of the oxycodone withdrawn at 0743 on May 14, 2018 *because the medication was administered to Patient 1*." Respondent's Exceptions at 1 (emphasis added). First, Respondent's proposed changes are not supported by Respondent's testimony. PFD at 7-8, ("before she was able to administer the medications. . . she left Patient 1's room to assist with the combative patient. . . [and later] realized Patient 1's medications were missing from her pocket."). Secondly, there is a lack of any contemporaneous documentation of administration in the patient's medical record which could be relied upon. Staff's Exhibit 15 at 106, (lacking any documentation showing that the medication was administered at or around the time it was pulled). Third, Respondent admitted that "she failed to document the administration of this medication," and Charge II is written as a failure to document, not a failure to administer the medication, so regardless of whether the oxycodone was actually administered or not, it was not timely documented in the patient's medical record

when it would have been of use to subsequent care givers and could have led to an accidental overdose. Respondent's Exceptions at 1; Staff's Ex. 5 at 5-6. Accordingly, there is no support for Respondent's proposed changes that she administered the Oxycodone pulled at 0743 on May 14, 2018 to Patient 1. Furthermore, if, as Respondent asserts, that "the Tramadol withdrawn at 1105 and the oxycodone withdrawn at 1106 are the medications" that are at issue in Formal Charge IV, then Staff would argue that this is further support that Respondent failed to document either administration of the Oxycodone pulled at 0743 as alleged in Formal Charge II, and/or in the alternative, failed to document wastage of the Oxycodone pulled at 0743 as alleged in Formal Charge III. Staff's Exhibit 15 at 106, (lacking any documentation showing that the medication was administered at or around the time it was pulled); Staff's Exhibit 13 at 1 showing Respondent did not waste or return any medication on May 14, 2018. Staff would further argue that Respondent's proposed change that "Approximately 1340 on May 14, 2018. . .Respondent . . . lost Patient 1's tramadol. . . and oxycodone. . . during a Code Gray" adds nothing of substance to Findings of Fact Nos. 7-11, which covers Respondent's withdrawal, failure to secure, loss, and lack of documentation of the medications. *Compare* Respondent's exceptions at 2, *with* PFD at 19.

With regard to Respondent's proposed Conclusions of Law Nos. 6 and 7, Staff would agree that "Respondent's failure to document the administration of oxycodone to Patient 1 at or shortly after 0743" is sanctionable; however, Staff would disagree that Respondent's failure to document the administration of Oxycodone to Patient 1 at or shortly after 0743 as alleged in Charge II somehow eliminates her culpability for later failing to "take precautions to secure Patient 1's oxycodone and tramadol" pulled at or around 11:05-11:06 am during the code grey at 1:40 pm as alleged in Charge IV. Respondent's Exceptions at 2-3; PFD at 19; Staff's Exhibit 9 at 1-2. Staff would also reiterate the ALJ's conclusion that Respondent "did not offer any reasonable

explanation of why or how the medications could have fallen out of her pocket(s)," assuming she did in fact place them in her pockets. PFD at 14.

With regard to the sanction, were Respondent to provide the Board with evidence that she has been regularly tested for drugs of concern on at least a monthly basis for twelve months, then Staff would be willing to consider a three-year probated suspension order in which Respondent would submit to the Board's standard drug and alcohol testing requirements as well as the employment supervision and continuing education requirements as previously specified the ALJ's PFD. Respondent's exceptions at 3-4; PFD at 18. However, without credible evidence that Respondent has in fact been sober for at least a year, Staff believes an "enforced suspension of Respondent's license until she has shown her sobriety" as originally recommended in the ALJ's PFD is appropriate because "the primary objective of a sanction is to ensure the protection of the public." PFD at 18.

Finally, while Staff did not file exceptions because it agreed with the overall result reached by the ALJ in this PFD, Staff believes that Finding of Fact No. 14 was reached without a properly applying the law. Tex. Gov't Code 2001.058(e)(1). Staff believes that Staff's evidence regarding Respondent's cocaine use as alleged in Charge VII should have been considered by the ALJ. Staff's Exhibit 17 at. 1. In *March v. Victoria Lloyds Ins.*, the Fort Worth Court of Appeals held that "[t]he report [of blood alcohol level] was admissible without accompanying expert testimony. *March v. Victoria Lloyds Ins.*, 773 S.W.2d 785, 789 (Tex.App.—Fort Worth 1989, writ denied). Similarly, the Amarillo Court of Appeals held in *National Std. Ins. v. Gayton,* that "nontestifying doctors' opinions or diagnoses included in medical records. . . upon proper authentication. . . are rendered admissible." *National Std. Ins. v. Gayton*, 773 S.W.2d 75, 77 (Tex.App.—Amarillo 1989, no writ). Respondent did not object to the authenticity of the toxicology report and it was admitted

into evidence as a business record accompanied by an affidavit. Tex. R. Evid 803(6), 902(10). While Staff agrees that the ALJ's "comprehension of the significance of the test results would have been enhanced by expert testimony," Staff does not believe that an expert's interpretation of the results was necessary to understand that the report was evidence that there was cocaine in Respondent's urine. *March v. Victoria Lloyds Ins.*, 773 S.W.2d 785, 789 (Tex.App.—Fort Worth 1989, writ denied); Staff's Exhibit 17 at. 1. Furthermore, Staff would also point out that Staff frequently provides medical records containing medical opinions, diagnoses and test results which are admitted into evidence and considered despite Staff not always offering expert testimony. *National Std. Ins. v. Gayton*, 773 S.W.2d 75, 77 (Tex.App.—Amarillo 1989, no writ). Moreover, many of the concerns regarding testing protocol, reliability, and validity are described in the General Overview of Laboratory Procedure. PFD at 16; Ex. 17 at 1-4. Accordingly, Staff believes that legally, Staff's Exhibit 17 should have been given some weight by the ALJ. PFD at 11, Footnote No. 29.

Respectfully submitted,

TEXAS BOARD OF NURSING

Helen Kelley

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SUSAN NICOLE DAMSKI, SOAH Docket No. 507-20-2653

CERTIFICATE OF SERVICE

I hereby certify by my signature below that a true and correct copy of *Staff's Response to Respondent's Exceptions to Proposal for Decision* has been provided on October 6, 2020, to: Marc M. Meyer, Attorney, via email: marc@marcmeyerlawfirm.com.

Helen Kelley

Helen Kelley, Assistant General Counsel

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

October 26, 2020

VIA EFILE TEXAS

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

RE: Docket No. 507-20-2653; Texas Board of Nursing v Susan Nicole Damski, RN830260

Dear Ms. Thomas,

On September 4, 2020, the undersigned Administrative Law Judge (ALJ) issued a Proposal for Decision (PFD) in the above-referenced case. On September 21, 2020, counsel for Respondent, Susan Nicole Damski RN830260, timely filed exceptions to the PFD, specifically to Findings of Fact Nos. 7-11 and the recommended sanction. On October 6, 2020, staff (Staff) of the Texas Board of Nursing (Board) filed a response to Respondent's exceptions.

Finding of Fact No. 7 states that "[o]n the morning of May 14, 2018, while employed at CHI, Respondent withdrew one unit of oxycodone and one unit of tramadol from the medication dispensing system for Patient 1." Respondent argues that the Findings of Facts should be changed to reflect that at "0743 on May 14, 2018, Respondent withdrew 5 mg of oxycodone and administered the medication to Patient 1" and "Respondent was not required to document wastage of the oxycodone withdrawn at 0743 on May 14, 2018, because the medication was administered to Patient 1." There is no evidence in the record, however, that Respondent administered *any* oxycodone to Patient 1 on the morning of May 14, 2018, whether around 0743 or 1106. Indeed, had the preponderance of the evidence supported a finding that Respondent actually administered oxycodone to Patient 1 any time on the morning of May 14, 2018, Staff would have also met its burden of proof on Charge II because there was no documentation to support Respondent's administration of the medication. The preponderant evidence demonstrated that Respondent should have documented wastage of Patient 1's oxycodone

and tramadol she withdrew that morning (whether at 0743 or 1106), and Respondent failed to take precautions to secure Patient 1's oxycodone and tramadol in that she lost the medications without a valid excuse. *See* PFD at 19, FoF 8-9.

Respondent further requests a finding that at "[a]pproximately 1340 on May 14, 2018, and at the direction of her preceptor, Ernest Okeke, Respondent prepared Pharmacy Variance Reports to document that she lost Patient 1's tramadol withdrawn at 1105 and oxycodone withdrawn at 1106 and lost during a Code Gray at CHI." The PFD, however, already contains a finding regarding Respondent's Pharmacy Variance Reports. *See* PFD at 19, FoF 9.

Finally, Respondent argues that a sanction of a one-year enforced suspension followed by a three-year probated suspension is excessive and does not take into account the mitigating evidence presented by the Respondent, specifically her testimony regarding drug testing. Respectfully, the mitigating and aggravating factors were appropriately weighed and balanced in this matter. Although Respondent correctly notes that Respondent's dismissal from TPAPN was based on a "technical" violation, Respondent's loss of Patient's 1 medications was serious and similar to prior incidents involving Respondent, as described in her Agreed Order. *See* PFD at 19, FoF 10. Respondent testified that she was arrested for driving while intoxicated during a time in which she was either enrolled or shortly after her dismissal from the Texas Peer Assistance Program for Nurses (TPAPN), and she argues her testimony that her probation has not been revoked is evidence of her sobriety. TPAPN is in the best position to determine whether and what type of documentary evidence of her drug testing history (which was not offered at the hearing) will satisfy the requirements to prove sobriety for one year. Given that the few mitigating and numerous aggravating factors were appropriately weighed and balanced in this matter, the ALJ declines to change the recommended sanction.

The ALJ notes that Staff asserted in its response that that Finding of Fact No. 14 was reached without a properly applying the law in denying the admission of Staff's Exhibit 17. For the reasons stated at the hearing and provided in the PFD, and because Staff did not timely file exceptions to the ruling, the ALJ declines to reconsider Finding of Fact No. 14 and the determination on Charge VII. Based on the foregoing, Respondent's exceptions are respectfully OVERRULED, and the PFD is ready to be presented to the Board for a final decision.

Srinivas Behara
Administrative Law Judge

VB/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**

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