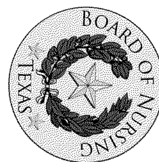

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

DOCKET NUMBER 507-20-3473

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE		
NUMBER 236013,	**§**	**OF**
ISSUED TO		
CINDY FARRELL TOW	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: CINDY FARRELL TOW
C/O MARC M. MEYER, ATTORNEY
525 WOODLAND SQUARE BLVD.
SUITE 250
CONROE, TX 77384

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

At the regularly scheduled public meeting on April 22-23, 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 the Respondent's exceptions to the PFD; the ALJ's final letter ruling of December 28, 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 November 6, 2020. Staff filed a response to Respondent's exceptions to the PFD on November 20, 2020. On December 28, 2020, the ALJ issued 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 the Respondent's exceptions to the PFD; the ALJ's final letter ruling of December 28, 2020; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

The ALJ found that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) & (13)[1]. A Warning with Stipulations or a Reprimand with Stipulations is authorized by the Boards Disciplinary Matrix for a second tier, sanction level I sanction[2]. The Board agrees with the ALJ that a Warning with Stipulations is the most appropriate sanction in this case.

The Respondent's conduct posed a serious risk of harm to the patient[3]. Privigen is a dangerous blood product, and the patient was particularly vulnerable due to her chronic immunity issues[4]. Additionally, because there were two instances of the infusions exceeding the maximum rate, the Respondent's conduct cannot be considered isolated in nature[5]. Further, by pre-writing her nursing notes, changing the pump settings without a physician's order, and recording time entries that were not accurate, the ALJ found that the Respondent's conduct was intentional and implicated a lack of truthfulness[6]. With regard to mitigation, the Respondent has a long history of nursing practice without any prior complaints or discipline, and she presented evidence of good professional character subsequent to this event[7].

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), that a Warning with Stipulations is the most appropriate sanction in this case.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a documentation course, and a critical thinking course[8]. 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. Supervisory requirements are intended to prevent additional violations from

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[1] See page 17 of the PFD.

[2] 22 Tex. Admin. Code §213.33(b).

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

[4] See *id.*

[5] See *id.*

[6] See *id* and adopted Finding of Fact Number 31.

[7] See *id* and adopted Findings of Fact Numbers 28 and 32.

[8] 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.

occurring and to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The Board also agrees with the ALJ 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. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(3)[9].

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

I. COMPLIANCE WITH LAW

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

II. UNDERSTANDING BOARD ORDERS

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

III. REMEDIAL EDUCATION COURSE(S)

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

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality,

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[9] 22 Tex. Admin. Code §213.33(e)(3), which authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least one year under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

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 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.

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.

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

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) 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:** For the duration of employment as a Nurse 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 four (4) quarters [one (1) year] of employment as a nurse.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

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

Entered this 22nd day of April, 2021.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; 507-20-3473 (October 22, 2020)

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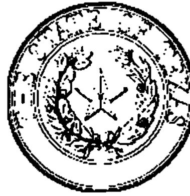
7-20-3473
'22/2020 1:20 PM
ATE OFFICE OF
MINISTRATIVE HEARINGS
nnie Roland, CLERK

FILED
507-20-3473
10/22/2020 1:14 PM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK



State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

October 22, 2020

VIA E-FILE 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. 507-20-3473; Texas Board of Nursing v. Cindy Tow

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507, a SOAH rule which may be found at www.soah.texas.gov.

Srinivas Behara
Administrative Law Judge

VB/lc
Attachment

xc: Jacqueline A. Strashun, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA E-FILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD of Hearing on the Merits) – **VIA E-FILE TEXAS and INTERAGENCY MAIL**
Marc M. Meyer, Marc Meyer Law Firm, 525 Woodland Square Blvd., Suite 250, Conroe, TX 77384-2212 - **VIA E-FILE TEXAS**

SOAH DOCKET NO. 507-20-3473

TEXAS BOARD OF NURSING, **Petitioner**	§ § §	**BEFORE THE STATE OFFICE**
v.	§ §	**OF**
CINDY FARRELL TOW, RN, **Respondent**	§ §	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against the Registered Nurse (RN) license held by Cindy Farrell Tow (Respondent). Staff filed formal charges against Respondent alleging that on two occasions in 2016, Respondent failed to infuse intravenous medication to a patient (V.S.) at the physician-ordered rates. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the allegations by a preponderance of the evidence, and recommends that the Board issue a warning with stipulations.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

ALJ Srinivas Behara of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits by telephone conference on August 18, 2020. Assistant General Counsel Jacqueline A. Strashun represented Staff. Respondent appeared and was represented by attorney Marc Meyer. The hearing concluded that day and the record closed on September 17, 2020, to allow the parties to file written closing briefs.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

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

unprofessional conduct (pursuant to Code § 301.452(b)(10)) or failure to conform to minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm (pursuant to Code § 301.452(b)(13)).[1] Staff asserted that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as several Board rules.[2]

Board Rule 217.11 discusses minimum acceptable standards of nursing practice, four of which Staff alleged were not met by Respondent:

- **Board Rule 217.11(1)(A)**: Nurses must know and conform to the Texas Nursing Practice Act, the Board's rules and regulations, and federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice;
- **Board Rule 217.11(1)(B)**: Nurses must implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(C)**: Nurses must know the rationale for and the effects of medications and treatments and shall correctly administer the same; and
- **Board Rule 217.11(1)(M):** Nurses must institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

Board Rule 217.12 discusses unprofessional conduct, and Staff alleged Respondent is subject to sanction under three provisions of that rule for:

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform 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)**: Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings; and

[1] Texas Occupations Code (Code) § 301.452(b) was amended effective September 1, 2017. The amendment did not substantively affect the Code provisions at issue in this case.

[2] 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 ____." Additionally, the references are to the rules in effect at the time of the alleged behavior in 2016. The Board's rules were revised effective February 25, 2018, 43 Tex. Reg. 1098. The amendments removed the words "carelessly or repeatedly" before "failing" in Board Rule 217.12(1)(B) and the words "careless or repetitive" before "conduct" in Board Rule 217.12(4). Also deleted from Board Rule 217.12(4) was the sentence, "Actual injury to a client need not be established."

- **Board Rule 217.12(4)**: Careless or repetitive conduct that may endanger a client's life, health, or safety, without requiring a showing of actual harm. Actual injury need not be established.

Board Rule 213.33 sets out a disciplinary matrix (Matrix) intended to match the severity of the sanction imposed to the nature of the violation at issue, taking into account mitigating and aggravating factors.[3] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction.

Staff had the burden of proving its allegations by a preponderance of the evidence.[4] In two formal charges, Staff alleges that on March 5 and April 2, 2016, while employed as an RN with OptionCare in Irving, Texas, Respondent failed to ensure that she performed intravenous immunoglobulin infusions (IVIG) of the medication Privigen to V.S. at the physician-ordered rates. Specifically, according to Staff, Respondent manually changed and increased the maximum rate of the fourth and final dose on the IVIG pump from 120 mL/hr to 150 mL/hr, which exposed V.S. unnecessarily to a risk of harm from fluid volume overload.

III. DISCUSSION

Staff offered 13 exhibits, all of which were admitted, and called as witnesses: three of Respondent's former coworkers at OptionCare; V.S.; and Staff's Board consultant. Respondent testified on her own behalf and called one former co-worker as a witness. Respondent also offered and the ALJ admitted the written character testimony from three witnesses on Respondent's pre-filed witness list.

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[3] Board Rule 213.33; *see also* Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[4] 1 Tex. Admin. Code § 155.427.

A. Staff's Evidence

1. Christina Cerreta, RN

Christina Cerreta has been a nurse in Texas for over 40 years. In 2016, she was OptionCare's Alternate Supervising Nurse, Clinical Nurse Coordinator, and Patient Care Coordinator. Her responsibilities included managing clinical staff, staffing new cases, educating staff on infusion requirements, speaking with patients about their care, and scheduling infusions. Ms. Cerreta supervised Respondent and was involved in OptionCare staff's delivery of home health IVIG nursing services to V.S. at her home. She spoke to V.S. once a month about her IVIG of Privigen for treating hypogammaglobulinemia, which is a chronic medical condition affecting the immune system. Respondent had been V.S.'s OptionCare nurse since 2009.

Ms. Cerreta described the general steps to prepare for administration of IVIG to patients. A few days before a patient's regularly scheduled IVIG appointment, Ms. Cerreta would review the physician's IVIG order and other medical records to ensure that the patient's infusion rates and criteria were accurately and correctly assigned to the pump. In this case, OptionCare used the Curlin 6000 infusion pump. Ms. Cerreta then pre-programmed the pump according to the physician-ordered rates and amount of total infusion. Ms. Cerreta then certified on a Curlin 6000 Programming Worksheet form that she accurately pre-programmed the pump according to the physician's order. The pharmacist on duty reviewed the pump and physician's order to double check it was pre-programmed correctly, and signed and certified the review. After this two-step confirmation process, the pump was "ready to go" so that the nurse could arrive at the patient's home, pre-assess the patient, administer pre-infusion medications (which would take up to 30 minutes), and simply hook the patient up with the pump and turn on the pre-programmed pump for infusion.

On March 3, 2020, Ms. Cerreta pre-programmed Curlin Pump #116062 for V.S.'s infusions scheduled on March 5, 2016, and April 2, 2016, as follows:[5]

	Dose Number	**Amount of Privigen**	**Rate**	**Time**
	1 of 4	15 mL	30 mL/hr	30 min
	2 of 4	30 mL	60 mL/hr	30 min
	3 of 4	45 mL	90 mL/hr	30 min
	4 of 4	660 mL	120 mL/hr (maximum rate)	5 hrs 30 min
Total:		**750 mL**		**7 hrs**

Ms. Cerreta testified that after each dose was administered, the pump would make an audible beep sound. The beep would alert the nurse that: the pump had completed the dose; the pump was moving onto the next pre-programmed dose; and it was time to check the patient's vital signs (temperature, pulse, respirations, and blood pressure). Ms. Cerreta stated that based on V.S.'s dosage amount and the ordered rate of infusion, the administering nurse would have left V.S.'s home about 15 minutes after the fourth dose was completed for a total time at V.S.'s home around eight hours.[6]

Ms. Cerreta testified that under OptionCare's policies and procedure, the nurse was required to take the following steps if the nurse needed to change any pre-programmed infusion rates: notify OptionCare staff and receive authorization from a practitioner for a change to the physician-ordered rates or amount; enter a code on the pump to bypass the pre-programmed settings; and indicate the reason for the change in the nurse's notes. Ms. Cerreta testified that the bypass code on the Curlin pump can be determined by reviewing the four digits on the back of the pump's label and adding five digits from the patient's zip code. Ms. Cerreta further testified that OptionCare's policy prohibited teaching patients how to change the pre-programmed settings and further prohibited giving patients the pump code.

[5] Staff Ex. 9.

[6] *See* Staff Ex. 10 at 9, 12.

Around April 25, 2016, Ms. Cerreta called V.S. to schedule an IVIG for her May infusion. According to Ms. Cerreta, V.S. requested that she be assigned a different nurse because Respondent allegedly had given V.S. an upper respiratory infection since her last infusion on April 2, 2016, and V.S. had to miss work for several days to recuperate. Ms. Cerreta further testified that V.S. conveyed concerns that Respondent had been changing the infusion pump program to run her medication at a higher rate of 150 mL/hr than her maximum infusion rate of 120 mL/hr, as ordered by her physician. V.S. informed Ms. Cerreta that she had seen those higher infusion readouts on the pump screen. V.S. also notified Ms. Cerreta that Respondent had been charting in the nurse's notes that her blood pressure readings were lower than what they actually were. Finally, V.S. reported to Ms. Cerreta that for the prior six months, Respondent had been coming to her house later than she was scheduled to come for the infusions and leaving her home much earlier than she was supposed to leave. Specifically, V.S informed Ms. Cerreta that Respondent was leaving closer to 1:30 p.m. rather than the normal time of 3:30 p.m.

Ms. Cerreta assigned V.S. a new nurse and escalated the complaint to her supervisor, Janette Nealy. At Ms. Nealy's direction, Ms. Cerreta also notified OptionCare's Pharmacy Manager to begin an investigation into the patient's pump history and to ascertain whether or not V.S.'s complaints about the excessive pump infusion rates could be verified.

2. Drushti Dave, Pharm. D.

In 2016, Dr. Dave was OptionCare's Director of Pharmacy. She has significant expertise in infusion pump therapy, including operation of the Curlin brand of infusion pump. According to Dr. Dave, the Curlin 6000 pump is considered the "Cadillac" of patient infusion pumps in the IVIG industry, and the slogan in the pump business about Curlin pump histories is that "the pump does not lie." She stated that the pump is very expensive but user-friendly and extremely reliable because it continually records and saves all pump event data for the life of the pump. Dr. Dave testified that Privigen is a blood product and because IVIG is a high-risk therapy, the patient cannot self-administer the infusion. Dr. Dave described side effects of an IVIG of Privigen, including increased blood pressure, increased heart rate, nausea, headaches, fever, and chills. Privigen has two FDA black box warnings.

Dr. Dave testified that after she received the request from Ms. Cerreta, she identified V.S.'s specific pump through the Programming Worksheet and had it returned to OptionCare's Pump Depot.[7] Dr. Dave requested a copy of the pump history report. She verified that it was the correct pump and compared the pump history report with V.S.'s medical records and pharmacy records and Respondent's infusion records from the IVIGs on March 5, 2016, and April 2, 2016. Based on the pump history, Dr. Dave made the following observations for the March 5, 2016 infusion:[8]

- Respondent turned the pump on and viewed the program at 8:19 a.m. The pump was in "Lock 1" mode, which means the nurse did not need to enter a code to change the program.
- Pump settings were physically modified at 8:19 a.m. to change and increase the pre-programmed settings for dose four from 120 mL/hr to 150 mL/hr. No changes were made to the pre-programmed settings for doses one through three.
- Dose four started at 10:42 a.m. The infusion moved from 90 mL/hr to 150 mL/hr and continued at that rate until the infusion was complete at 1:35 p.m.
- The pump was turned off at 1:37 p.m.
- The total actual infusion time was 5 hours and 14 minutes.

Dr. Dave testified that the pump history indicated the pump was exclusively used on V.S. from March 5, 2016, through April 2, 2016. Dr. Dave noted that there was no direct evidence that Respondent was the one who changed the pump settings. Dr. Dave testified, however, that the pump does not allow for an accidental change and the rate had to be changed manually. Dr. Dave further testified that the first thing a nurse does when turning on the pump is review the pump screen, which shows all the presets for doses one through four. Dr. Dave noted that there was no record of Respondent calling the pharmacist to change an infusion rate.

Dr. Dave stated that for the April 2, 2016 infusion, the settings from the previous infusion on March 5, 2016, were set as the default. Accordingly, the fourth dose was 150 mL/hr. Dr. Dave

[7] Staff Ex. 7.

[8] Staff Ex. 7 at 6-8.

noted that Respondent turned on the pump at 8:08 a.m., the infusion started at 8:10 a.m., and the infusion was completed at 1:07 p.m. The total infusion time was 4 hours and 57 minutes. Dr. Dave further noted that a nurse could reduce the total infusion time by at least 1 hour and 15 minutes if the infusion rate at dose four were to be increased to 150 mL/hr rather than the physician-ordered maximum rate of 120 mL/hr.

3. Janette Nealy, RN

Ms. Nealy became OptionCare's Director of Operations and Director of Nursing in 2015. Ms. Nealy testified that she received a report from Dr. Dave regarding pump history for Respondent's infusions of V.S. from March and April 2016. According to Ms. Nealy, the report confirmed V.S.'s complaints that Respondent had been infusing V.S. at an excessive infusion rate. On May 25, 2016, she and OptionCare's human resources representative met with Respondent regarding V.S.'s complaints.[9] Ms. Nealy testified about the meeting with Respondent:

- Respondent speculated that one of the pharmacists changed the pump or programmed it incorrectly;
- Respondent could not definitively state she did not change the infusion rate but did not recall doing so;
- Respondent stated that she always verified the pump setup but could not remember if she checked it on the days in question;
- Respondent stated that she confirmed the physician's orders before the infusion;
- Respondent stated that V.S.'s blood pressure always ran low;
- Prior to Respondent being assigned as V.S.'s nurse in 2009, V.S. had alleged that a different nurse was incorrectly recording blood pressure readings; and
- Respondent could not account for the difference between the time she recorded and the pump history end time.

[9] Staff Ex. 6 at 45-46.

Ms. Nealy stated that she had the incorrect pump history at the meeting, so she scheduled another meeting to have Respondent return and would show Respondent the pump history. Respondent resigned on May 27, 2016, before the meeting could occur. In the resignation letter, Respondent stated: "[t]he rate on the pump was too fast. On my last visit [April 2, 2016], I have no memory of actually reviewing the variable rate program on her pump, but I review EVERY PUMP and EVERY DOCTORS ORDER, before I start their infusions. If her rate was changed, it was either done accidentally or not by me . . . . I cannot explain the pump readings. I wish I could."[10]

4. V.S.

V.S. testified that she had been receiving IVIG of Privigen since 2005, and Respondent had been her OptionCare infusion nurse since 2009. Her infusion appointments typically occurred on the first Saturday of each month. She testified that she never infused herself and she did not know the code to access the pump. V.S. stated that she regularly read the images on the visibly lit screen of the pump over the course of her infusion process, and she also could see her blood pressure readings on her cuff blood pressure monitor screen.

V.S. testified that Respondent would typically arrive at V.S.'s house around 8 a.m. and leave when the treatment was complete at around 4 p.m. V.S. testified that for about six months prior to her March 2016 infusion, Respondent began coming in late to the scheduled infusion appointments and leaving the appointment much earlier than normal. According to V.S., Respondent would typically leave at the beginning of the second showing of her favorite American Western television show "The Virginian," which would start at 3 p.m. V.S. testified that she knew Respondent was leaving early because the show had not started. V.S. further testified that she was not assessed for vital signs after 1 p.m. V.S. admitted, however, that she counter-signed infusion vital flow records for March 5 and April 2, 2016, which indicated that she was assessed for vital

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

signs after 1 p.m. and that dose four was completed at 3 p.m.[11] V.S. further admitted she never asked that Respondent correct the time entries even though she allegedly knew they were incorrect.

V.S. testified that she felt fine before the infusions but she began feeling sick during and after the infusions, including symptoms of nausea and bad headaches. She stated that the symptoms would often linger for up to two days. V.S. testified that she raised concerns about her health with Respondent but nothing changed. According to V.S., she saw Respondent punching or keying numbers into the pump before connecting her. V.S. testified that she looked at her pump screen on the last few infusions when she was in the bathroom alone, and the pump screen indicated an infusion rate of 150 mL/hr, and she understood the rate to be higher than the maximum rate ordered by her physician.

V.S. testified that Respondent was not correctly recording her blood pressure readings in the nurse's notes. Patient stated that when she would take Benadryl, her blood pressure would go down and she would question Respondent why, but Respondent would respond that the blood pressure was fine. V.S. admitted that she had previously requested a nurse change in 2009 because the nurse allegedly was not recording blood pressure correctly.

Finally, V.S. alleged that Respondent gave her an infusion when Respondent was sick with a cold, which Respondent allegedly passed to her. V.S. stated she felt it was finally time to bring her concerns to the attention of OptionCare staff and request a different nurse.[12] When asked why she did not raise her concerns earlier, V.S. testified that she "didn't want to rock the boat." V.S. stated that her current nurse does not adjust any settings on the pump and she feels fine after her IVIG appointments. V.S. also testified that her current nurse does not punch or key any numbers on the pump before beginning the IVIG.

5. Linda S. Laws, BSN, MSN, RN

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[11] Staff Ex. 10 at 9, 12.

[12] At the hearing, V.S. testified about several conversations she allegedly had with Respondent regarding Respondent's personal relationships with family and friends. The substance of the alleged conversations is irrelevant to this matter and is not addressed further in this proposal for decision.

Ms. Laws has been a nurse for 42 years. She has worked for the Board since 2011 and is currently a Practice Consultant for the Board. Her duties include answering questions regarding the Board's rules and their application to nursing practice and providing educational workshops to nurses. Ms. Laws is familiar with the Code and the Board's rules and uses them in her day-to-day work. Her written sworn testimony focused on the appropriate sanction the Board may fashion if Staff's charges are proven true. Specifically, Ms. Laws opined that under either Code § 301.452(b)(10) or Code § 301.452(b)(13), Respondent's conduct would be considered a Tier Two, Sanction Level I offense under the Board's Matrix.

Ms. Laws noted that Respondent's conduct was not an isolated incident as there were at least two instances of improper infusions. Ms. Laws also stated that Respondent's conduct resulted in actual physical harm to V.S., in the form of nausea and headaches. Ms. Laws described several aggravating factors. First, according to Ms. Laws, there was a significant issue of patient vulnerability because V.S. had a high risk of greater harm due to her chronic immunity issues. Second, Ms. Laws testified about the risky nature of blood product infusions. Finally, Ms. Laws noted that risk of harm in infusing at a rate in excess of the maximum rate ordered by the physician. Ms. Laws described mitigating factors, including Ms. Tow's 40 years of nursing experience and lack of any previous disciplinary actions. Based on the aggravating and mitigating factors presented, Ms. Laws recommended a disciplinary level of a warning with stipulations that would include: continuing education courses in nursing jurisprudence and ethics, critical thinking, and documentation; notification to her employer of the Board order; indirect supervision by the employer during the term of the Board order; and quarterly reports to the Board from the employing supervisor.

B. Respondent's Evidence

1. Respondent

Respondent described her long history in nursing, having been licensed by the Board since April 1976 under RN License No. 236013. Respondent has significant experience in home health services and infusion therapy, including IVIG. She testified about her general routine for

administering IVIG to V.S. She would arrive around 7:45 a.m., immediately record the time in the nurse's notes, discuss the past infusion, and start a general assessment. She testified it would take around 20-30 minutes to write her notes regarding the initial assessment.[13] She would pre-medicate V.S. by typically giving V.S. heartburn medicine and Benadryl to assist with nausea. Respondent stated that she checked V.S.'s respiratory system for wheezing and abnormal breathing sounds. On March 5, 2016, Respondent documented in clinical notes that V.S. had trace edema (fluid retention) and that V.S. complained of swelling in both feet the prior week.[14] The clinical notes further indicate that V.S. had a history of an aortic valve replacement.[15]

Respondent stated that she would always look at the pump programming to review the ramp up rate and highest rate before hooking up the IVIG and turning on the pump. She testified that she would scroll through the screen on the pump and was required to press the "yes" button to confirm that the program in the pump was set in the correct order. The screen review would take about one minute to perform. Respondent further stated that she would look at the label on the Privigen bag prior to starting, which would have also indicated the dose rates. Respondent testified that V.S. was sitting in a chair for most of the infusion unless she went to the bathroom. According to Respondent, V.S. would take a nap around noon and then wake up to watch television.

Respondent testified that prior to starting the infusion, she would pre-write in all assessment times and pump rates on the nurse's notes and/or vital sign assessment sheets so that she could fill in the appropriate vital signs at the time of assessment. The IVIG would take about one minute for everything to get started. Respondent would then assess V.S.'s vital signs every 15 minutes for the first hour and hourly thereafter. Respondent documented the fourth dose as 120 mL/hr until completed.[16] Each time V.S. was assessed, Respondent would document the observations in the nurse's notes.[17] Respondent testified that she took V.S.'s blood pressure and

[13] *See* Staff Ex. 10 at 8.

[14] Staff Ex. 10 at 9-10.

[15] Staff Ex. 10 at 11.

[16] *See* Staff Ex. 10 at 9.

[17] *See* Staff Ex. 10 at 9.

that it was displayed on a wrist cuff. She would then show the reading to V.S. and document the reading on the vital signs sheet. Respondent further testified that she did not see V.S. write down the blood pressure reading herself, and V.S. never informed Respondent that she may have incorrectly recorded the blood pressure reading. Respondent testified that, generally, she would not look at the pump after the first hour. She could not recall whether V.S.'s pump made a beeping sound or not when moving to the next dose.

Respondent denied that she made changes to the pump program. She testified that if she had made a program change, she would have needed to contact the on-call pharmacist to get an order to change the program. Respondent further denied that she left any appointment early. She testified that she accurately left at the documented time around 3:15 p.m. According to Respondent, she knew her timing was correct because The Virginian came on at 1 p.m. and 3 p.m., and she always left toward the middle of the second showing. Respondent stated that she recalled the time she left V.S.'s home because she disliked The Virginian but would endure two episodes of the show before leaving since it was the patient's choice. Respondent stated that on the two occasions at issue, V.S. never reported any symptoms of lethargy, fatigue, or headache prior to or after administering the IVIG.

Respondent identified three years' worth of performance evaluations showing that Respondent fully met all employment expectations and exceeded many expectations while employed at OptionCare. She testified that on May 25, 2016, she was at OptionCare's office for an in-service meeting when she was unexpectedly called into Ms. Nealy's office to meet with her and a human resources representative. She testified that she felt blindsided by the meeting and was shown a pump history that did not belong to V.S. Respondent testified that she never admitted to changing pump settings and did not recall being unclear about the denial. After resigning, Respondent began working at Ally Home Health in Richardson, Texas to continue performing infusion therapy.

2. Cass Weyandt, RN

Ms. Weyandt was an OptionCare nurse. Ms. Weyandt and Respondent are personal friends but she did not personally know anything about what happened regarding Respondent's care of V.S. Ms. Weyandt was assigned to administer IVIG to V.S. for several years before being dismissed from V.S.'s care in 2009. Ms. Weyandt testified that it was alleged she had been recording V.S.'s blood pressure incorrectly. Respondent took over for V.S.'s infusions after Ms. Weyandt was reassigned.

3. Character Evidence

Respondent submitted sworn written statements from three of Respondent's former and current co-workers: Collette Franklin, Rito Jasso, and Robert Cleveland. None of the individuals had personal knowledge of Respondent's care of V.S., but they provided positive character references and indicated that Respondent performs the same type of infusion work in her current employment. They described Respondent as highly professional, a staunch patient advocate, and thorough and accurate in her documentation. One witness stated that patients love her and frequently comment on her good nursing technique. The same witness further stated that Respondent's commitment to following physician's orders for all patients has never been in question.

C. Analysis

1. Violations

It was undisputed that on March 5 and April 2, 2016, V.S.'s fourth doses of Privigen were infused at a rate of 150 mL/hr, in excess of the physician-ordered rate of 120 mL/hr. The main question in this case is whether Respondent was responsible for the IVIG at the excessive rate. Staff proved by a preponderance of the evidence that she was.

The parties' testimonial evidence conflicted. V.S. testified that Respondent left her home early, but V.S. never wrote down when Respondent left her residence or reported it to OptionCare prior to scheduling the May 2016 infusion. V.S. also admitted that she signed off on the documented records showing that Respondent left V.S.'s home at 3 p.m. V.S. also claimed that Respondent was incorrectly documenting V.S.'s blood pressures. But, V.S. did not provide any documentation to support that allegation and she also signed the vital signs sheets affirming the blood pressure recordings. Finally, V.S. alleged that she got sick after Respondent came to one of her infusion appointments with an upper respiratory infection, but V.S. never provided any written documentation of the illness, nor did V.S. ever see a physician for the alleged illness. Respondent denied changing the pump rate. Other than Respondent and V.S., the other witnesses were not present for the infusions and could not testify as to what exactly occurred.

The documentary evidence, however, was uncontroverted. As Dr. Dave testified, the pump does not lie. The Curlin pump, known for its reliability and accurate recording of data, showed that Respondent turned V.S.'s pump on and viewed the program at 8:19 a.m. on March 5, 2016. Respondent admitted to turning on the pump. Dr. Dave testified that the pump does not allow for an accidental change and the rate had to be changed manually. There was no evidence to support an inference that V.S. turned the pump on and/or changed the rate on her own. The pump was in Respondent's control at the time the rate was changed. Respondent testified that she would have scrolled through the screen on the pump and was required to press the "yes" button to confirm the correct pump settings. The pump history shows that, almost contemporaneously with when the pump was turned on at 8:19 a.m., the pump settings were modified to increase the pre-programmed settings for dose four from 120 mL/hr to 150 mL/hr, with no changes being made to the pre-programmed settings for doses one through three. Given that there is no dispute Respondent was in possession of the pump at the time of the manual change, the only permissible inference from the evidence is that Respondent changed the rate, either carelessly or intentionally.

Respondent argues that her nursing documentation shows that she properly infused V.S. at the physician-ordered rate and that the Board did not cite her documentation as a potential violation of Board Rules. Staff, however, presented Respondent's documentation not as proof of a violation but instead to support the inference that Respondent should have known the rate was in excess of

the physician-ordered rate. Respondent testified that she pre-wrote in all the assessment times rather than record them at the time they occurred. For the March infusion, the pump history shows the pump was infusing at 150 mL/hour and an "alarm" event turning off the pump at 1:37 p.m. Respondent, however, recorded that the pump was infusing at 120 mL/hr and she allegedly took V.S.'s vital signs at 2 p.m. and 3 p.m. Respondent also recorded the total time at V.S.'s home of 7.5 hours when the pump records show the infusion took 5 hours and 14 minutes. Likewise, the April 2016 pump history demonstrates that the infusion completed at a rate of 150 mL/hr and it was turned off at 1:07 p.m. Respondent, however, recorded that the pump was infusing at 120 mL/hour and she recorded taking V.S.'s vital signs at 2 p.m. and 3 p.m. Respondent would have known she was not infusing V.S. at the correct rate for dose four if she had checked the pump screen, not pre-written assessment times, and checked her nurse's notes for accuracy.

With respect to minimum standards of nursing practice, Respondent's conduct violated the following Board Rules:

- **Board Rule 217.11(1)(A)**: Respondent failed to comply with the laws and rules pertaining to her area of infusion practice in that she increased the rate of the IVIG to a rate in excess of the maximum rate, which could have harmed V.S.;
- **Board Rule 217.11(1)(B)**: Respondent exceeded the physician-ordered infusion maximum rate of 120 mL/hr without proper authority to do so, and her acceleration of the IVIG treatment time was not in the interest of patient safety;
- **Board Rule 217.11(1)(C)**: Respondent did not meet the standard of care by incorrectly administering the IVIG of Privigen to V.S. in excess of the physician-ordered rate; and
- **Board Rule 217.11(1)(M)**: The infusion rate was increased to 150 mL/hr, which exceeded the physician-ordered maximum rate, and interventions required to prevent complications were not taken.

With respect to unprofessional or dishonorable conduct, Respondent violated the following Board Rules:

- **Board Rules 217.12(1)(A), (B)**: On March 5, and April 2, 2016, Respondent carelessly and repeatedly failed to perform to practice nursing in conformity with

the minimum acceptable level of nursing practice found in Board Rule 217.11 when Respondent violated the physician's order and increased V.S.'s maximum infusion rate above 120 mL/hr to 150 mL/hr; Respondent also pre-charted before nursing tasks or procedures actually took place, which is not within the standards of nursing practice; and

- **Board Rule 217.12(4)**: Respondent exhibited careless and repetitive conduct that could have endangered V.S.'s health by performing an infusion at an excessive rate.

The same conduct (administering infusions at a rate exceeding the physician-ordered rate) that violated minimum nursing standards also constituted unprofessional conduct. Accordingly, based on these Board Rule violations, Respondent is subject to disciplinary action under Code § 301.452(b)(10) and (13).

2. Sanctions

The ALJ finds that under either Code § 301.452(b)(13), failure to meet minimum standards of nursing practice, or under Code § 301.452(b)(10), unprofessional or dishonorable conduct, Staff established violations that subject Respondent to sanction by the Board. After reviewing the guidelines set out in the Board's Matrix and the evidence pertinent to the relevant mitigating and aggravating factors, under either Code provision, Respondent's conduct should be considered a Second Tier, Sanction Level I offense.

The evidence established that infusing V.S.'s medication in excess of the physician-ordered rate could have harmed V.S. Privigen is a dangerous blood product. Its side effects include increased blood pressure, increased heart rate, nausea, headaches, and fever and chills. V.S. complained of feeling sick, including headaches and nausea, after Respondent administered the IVIG. Respondent also recorded that V.S. exhibited signs of edema prior to the infusions. Infusing at a higher rate could have caused even more fluid overload and swelling. Taking into account the patient's high level of vulnerability based on V.S.'s chronic immunity issues and the risky nature of the blood product infusions, there was a serious risk of harm. Because there are at least two acts of infusions exceeding the maximum rate, Respondent's conduct cannot be considered isolated.

Accordingly, under either Code § 301.452(b)(10) or (13), Respondent's violations are appropriately considered as Second Tier offenses.

The recommended sanction depends on whether the aggravating and mitigating factors establish that the offense should be considered under Sanction Level I or II. For both Code § 301.452(b)(10) and (13), the additional factors the Board should consider, based on the evidence in this case, are : (1) evidence of actual or potential harm to patients, clients, or the public; (2) evidence of a lack of truthfulness or trustworthiness; (3) evidence of practice history; (4) evidence of present fitness to practice; (5) whether the person has been subject to previous disciplinary action by the Board; (6) the deterrent effect of the penalty imposed; (7) the length of time the person has practiced; (8) whether the person is being disciplined for multiple violations of the Code or its derivative rules and orders; (9) the seriousness of the violation; and (10) evidence of good professional character as set forth and required by Board Rule 213.27.[18]

Respondent presented mitigating factors including her successful long history of nursing without any prior complaints or discipline. She also presented evidence of good professional character. On the other hand, Staff presented evidence of several aggravating circumstances. There were at least two instances of Respondent infusing at the excessive rate. In addition, as discussed above, there was a serious risk of harm to a vulnerable patient. In addition, by pre-writing her nursing notes, changing the pump settings without a physician order, and recording time entries that were not accurate, the preponderant evidence proved that Respondent's conduct was likely intentional and called her truthfulness into question. Balancing the evidence presented, Respondent's conduct falls under Sanction Level I. The recommended penalty is a warning with the following stipulations: continuing education courses in nursing jurisprudence and ethics, critical thinking, and documentation; notification to her employer of the Board order; indirect supervision by the employer during the term of the Board order; and quarterly reports to the Board from the employing supervisor. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law:

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[18] Board Rule 213.33(c).

IV. FINDINGS OF FACT

1. Cindy Farrell Tow (Respondent) has been licensed as a Registered Nurse (RN) by the Texas Board of Nursing (Board) since April 1976, under RN License No. 236013.

2. Respondent was employed as an RN with OptionCare in Irving, Texas.

3. Starting in 2009, Respondent was assigned as the OptionCare RN to perform intravenous immunoglobulin infusions (IVIG) of the medication Privigen to a patient (V.S.) at the patient's home.

4. A physician ordered the IVIG of Privigen to treat V.S.'s hypogammaglobulinemia, which is a chronic medical condition affecting the immune system.

5. Privigen is a blood product and because IVIG is a high-risk therapy, the patient cannot self-administer the infusion. The side effects of an IVIG of Privigen include increased blood pressure, increased heart rate, nausea, headaches, and fever and chills.

6. On March 3, 2016, Christina Cerreta, OptionCare's Alternate Supervising Nurse, Clinical Nurse Coordinator, and Patient Care Coordinator, reviewed the physician's IVIG order for V.S. and other medical records to ensure that V.S.'s infusion rates and criteria were accurately and correctly assigned to a Curlin 6000 infusion pump. V.S. was assigned to Curlin Pump #116062.

7. Ms. Cerreta pre-programmed the pump according to the physician-ordered rates and amount of total infusion for V.S. Ms. Cerreta also certified on a Curlin 6000 Programming Worksheet form that she accurately pre-programmed the pump according to the physician's order.

8. OptionCare's pharmacist on duty reviewed the pump and the physician's order to double check it was pre-programmed correctly, and signed and certified the review.

9. After this two-step confirmation process, the pump was ready so that the nurse could arrive at a patient's home, pre-assess the patient, administer pre-infusion medications (which would take about 30 minutes), and simply connect the patient to the pump and turn on the pre-programmed pump for infusion.

10. The pump does not allow for an accidental change and the rate had to be changed manually.

11. The pre-programmed infusion rates for V.S.'s infusions of March 5, and April 2, 2016, were as follows:

	Dose Number	Amount of Privigen	Rate	Time
	1 of 4	15 mL	30 mL/hr	30 min
	2 of 4	30 mL	60 mL/hr	30 min
	3 of 4	45 mL	90 mL/hr	30 min
	4 of 4	660 mL	120 mL/hr (maximum rate)	5 hrs, 30 min
Total:		**750 mL**		**7 hrs**

12. On March 5, 2016, Respondent arrived at V.S.'s home and documented in clinical notes that V.S. had trace edema (fluid retention) and V.S. complained of swelling in both feet the prior week.

13. The clinical notes indicate that V.S. had a history of an aortic valve replacement.

14. Before administering the IVIG to V.S., Respondent scrolled through the screen on the pump and was required to press the "yes" button to confirm that the program in the pump was preset in the correct order for doses one through four.

15. Respondent pre-wrote in all assessment times and pump rates on the nurse's notes and/or vital sign assessment sheets.

16. Respondent turned the pump on and viewed the program at 8:19 a.m. The pump was in "Lock 1" mode, which means the nurse did not need to enter a code to change the program.

17. At 8:19 a.m., Respondent modified the pump settings to increase the pre-programmed settings for dose four from 120 mL/hr to 150 mL/hr, in excess of the maximum rate prescribed by V.S.'s physician.

18. No changes were made to the pre-programmed settings for doses one through three.

19. Dose four started at 10:42 a.m. The infusion moved from 90 mL/hr to 150 mL/hr and continued at that rate until the infusion was complete at 1:35 p.m. The pump was turned off at 1:37 p.m.

20. The total actual infusion time for the March 5, 2016 infusion was 5 hours and 14 minutes. However, Respondent recorded the total time visiting V.S. as 7 hours and 15 minutes and that she left V.S.'s home at 3:15 p.m.

21. The same pump was not used on any patient other than V.S. before April 2, 2016.

22. The pump for V.S.'s April 2, 2016 infusion contained the same settings from the previous infusion on March 5, 2016, with the fourth dose at 150 mL/hr instead of 120 mL/hr.

23. On April 2, 2016, Respondent turned on the pump at 8:08 a.m. The infusion for V.S. started at 8:10 a.m. Respondent completed the infusion at 1:07 p.m., for a total infusion time of 4 hours and 57 minutes.

24. With the increased infusion rate of 150 mL/hr rather than the physician-ordered maximum rate of 120 mL/hr, the total infusion time for dose four was reduced by at least 1 hour and 15 minutes.

25. V.S. complained of nausea and headaches after the infusions of March 5 and April 2, 2016.

26. There was no evidence that Respondent incorrectly recorded V.S.'s blood pressure readings.

27. There was no evidence that Respondent gave V.S. an upper respiratory infection.

28. Respondent presented evidence of the following mitigating factors: she has been practicing as a nurse for over 40 years; she had no previous disciplinary history; and she demonstrated good professional conduct while working as an RN at Ally Home Health, since 2016.

29. On March 23, 2020, staff of the Board (Staff) sent Respondent a Notice of Hearing and Formal Charges. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

30. Administrative Law Judge (ALJ) Srinivas Behara of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits telephonically on August 18, 2020. Assistant General Counsel Jacqueline A. Strashun represented Staff. Respondent appeared and was represented by attorney Marc Meyer. The hearing concluded that day and the record closed on September 17, 2020, upon receipt of Staff's final closing brief.

31. Aggravating factors related to Respondent's conduct include a serious risk of harm to a vulnerable patient and lack of truthfulness.

32. Respondent demonstrated mitigating factors including good professional conduct and no history of prior complaints or disciplinary history.

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 of the allegations of misconduct and aggravating factors. Respondent had the burden of proof by a preponderance of the evidence of mitigating factors. 1 Tex. Admin. Code § 155.427.

5. Respondent is subject to sanction because of her failure to conform to generally accepted nursing standards in applicable practice settings by: failing to comply with the laws and rules pertaining to her area of infusion practice in that she increased the rate of the IVIG to a rate that could have harmed V.S.; exceeding the physician-ordered infusion maximum rate of 120 mL/hr without proper authority to do so and not in the interest of patient safety; failing to meet the standard of care in administration of the IVIG; and failing to take interventions required to prevent complications. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(A), (1)(B), (1)(C), and (1)(M).

6. Respondent is subject to sanction because: she carelessly and repeatedly failed to perform to practice nursing in conformity with the minimum acceptable level of nursing practice found in 22 Texas Administrative Code § 217.11, when Respondent violated the physician's order and increased V.S.'s maximum infusion rate of Privigen above 120 mL/hr to 150 mL/hr; pre-charted before nursing tasks or procedures actually took place, which is not within the standards of nursing practice; and exhibited careless and repetitive conduct that could have endangered V.S.'s health by performing an infusion at an excessive rate. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (1)(B), and (4).

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

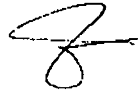
8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the Board's Disciplinary Matrix.

9. The Board may also consider any aggravating and mitigating circumstances set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue a Warning to Respondent with the following stipulations: continuing education courses in nursing jurisprudence and ethics, critical thinking, and documentation; notification to her employer of the Board order; indirect supervision by the employer during the term of the Board order; and quarterly reports to the Board from the employing supervisor.

Signed October 22, 2020.



SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

ACCEPTED
507-20-3473
11/9/2020 8:27 AM
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Jodi Brown, CLERK

DOCKET NO. 507-20-3473

IN THE MATTER OF PERMANENT CERTIFICATE RN NUMBER 236013 ISSUED TO CINDY FARRELL TOW, RESPONDENT	§ § § § §	**BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS**

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Cindy Farrell Tow, through her attorney, to file these Exceptions to the Proposal for Decision.

EXCEPTIONS

Findings of Fact Nos. Sixteen (16) – Seventeen (17); Nos. Nineteen (19) – Twenty (20); and Twenty-Two (22) – Twenty-Four (24): Respondent excepts to Findings of Fact Nos. Sixteen (16) – Seventeen (17); Nos. Nineteen (19) – Twenty (20); and Twenty-Two (22) – Twenty-Four (24) because they are not supported by the evidence. Specifically, Respondent argues that all seven Findings of Fact are premised on the testimony of Dr. Drushti Dave related to a printout of pump operations that is alleged to have been from the pump in question. However, as Dr. Dave admitted in the hearing, she was not the individual who ran the history on the pump.[1] The individual or entity that ran the pump history was not called to testify, not were Dr. Dave, or any of the other individuals who did testify in the hearing, present in Patient VS residence on either March 5th, 2016 or April 2nd, 2016.[2] Respondent therefore argues that this evidence should be given little to no weight, especially in comparison to the testimony of the Respondent and her documentary evidence that was contemporaneous with her infusion of Patient VS.[3] Thus, Respondent argues that Findings of Fact Nos. Sixteen (16) – Seventeen (17); Nos. Nineteen (19) – Twenty (20); and Twenty-Two (22) – Twenty-Four (24) should be removed from the proposal

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[1] Hearing Audio, at 3:37:18 – 3:37:25

[2] *Id.*, at 1:42:38 – 1:42:47. *See Also* 4:45:55 – 4:46:14.

[3] *See* Staff's Exhibit 10, at 9.

for decision.

Conclusions of Law Nos. Six (6) and Seven (7): Based on the foregoing arguments regarding Findings of Fact Nos. Sixteen (16) – Seventeen (17); Nos. Nineteen (19) – Twenty (20); and Twenty-Two (22) – Twenty-Four (24), Respondent excepts to Conclusions of Law Nos. Five (5) and Six (6). Specifically, Respondent asserts that these Conclusions of Law should be rewritten to indicate that Respondent is not subject to sanction based on the alleged actions.

Recommended Sanction: If the Administrative Law Judge upholds in part or in whole, Respondent excepts to the Sanction Recommendation asserted by the Administrative Law Judge in that a sanction of a warning with indirect supervision is excessive and does not take into account all of the mitigating evidence presented by the Respondent. Respondent notes Finding of Fact No. Thirty-Two (32) notes that "Respondent demonstrated mitigating factors including good professional conduct and no history of prior complaints or disciplinary history".[4] Respondent further notes there is evidence that Respondent has positive evidence related to Board Rule 213.33(c)(2), (3), & (8), in addition to the evidence noted by the Administrative Law Judge.

Respondent notes that even if the Respondent is liable for a Tier 2, Sanction level I disciplinary action of a warning, there is a lower level of supervision available than indirect supervision. The Board is also able to order a lower level of supervision, incident reporting, which does not require the Respondent to be employed in an institutional setting, but only requires that any issues with Respondent's practice be reported to the Board. Given the length of Respondent's practice, the lack of prior disciplinary action, and other mitigating factors, Respondent argues that incident reporting would be adequate to assure the safety of the public as is the mission of the Board of Nursing. Based on this, Respondent argues if the Administrative Law Judge does find cause for a disciplinary action, then a one-year warning with incident reporting requirements and completion of certain remedial education courses as designated by the Board to sufficient to ensure protection of the public and remediate Respondent's practice as a nurse.

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[4] Proposal for Decision, at 21.

PRAYER FOR RELIEF

Respondent, Cindy Farrell Tow prays that the honorable Administrative Law Judge:

1. Nos. Sixteen (16) – Seventeen (17); Nos. Nineteen (19) – Twenty (20); and Twenty-Two (22) – Twenty-Four (24)

2. Replace Conclusions of Law Nos. Five (5) and Six (6) with the following conclusions of law:

    a. Respondent is not subject to sanction for her actions on March 5th, 2016 or April 2nd, 2016 because of a failure to conform to generally accepted nursing standards in applicable practice settings, exceeding the physician-ordered infusion maximum, failing to meet the standard of care in administration of the IVIG; or failing to take interventions required to prevent complications. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(A), (1)(B), (1)(C), and (1)(M).

    b. Respondent is not subject to sanction for her actions on March 5th, 2016 or April 2nd, 2016 because she carelessly and repeatedly failed to perform to practice nursing in conformity with the minimum acceptable level of nursing practice found in 22 Texas Administrative Code § 217.11, pre-charted before nursing tasks or procedures actually took place, or exhibited careless and repetitive conduct that could have endangered V.S.'s health. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (1)(B), and (4).

3. In the alternative, if the Administrative Law Judge does find a violation of the Nursing Practice Act sanctionable by the Board, change the Sanction Recommendation to a warning for one year with incident reporting, and certain remedial education courses to be determined by the Board of Nursing; AND

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

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Respectfully submitted,

By: *Marc M Meyer*

Marc M. Meyer
State Bar No. 24070266
Attorney for Cindy Farrell Tow
525 Woodland Square Blvd., STE 250
Conroe, TX 77384-2212
Tel: 281.259.7575
Fax: 866.839.6920

CERTIFICATE OF SERVICE

This is to certify that on the 6th day of November, 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
William P. Clements Building
300 W. 15th Street, Suite 504
Austin, TX 78701-1649
VIA Texas electronic filing portal

Jacqualine Strashun, Assistant General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701
VIA Texas electronic filing portal

Marc M Meyer

Marc M. Meyer

DOCKET NO. 507-20-3473

IN THE MATTER OF PERMANENT CERTIFICATE NUMBERS RN 236013 ISSUED TO **CINDY FARRELL TOW**	§ § § § §	BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

CONFIDENTIAL AND UNDER SEAL

STAFF'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO PFD

Srinivas Behara, Administrative Law Judge

Administrative Hearing on the Merits: August 18, 2020

TEXAS BOARD OF NURSING
Jacqueline A. Strashun, Assistant General Counsel
State Bar No. 19358600
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-7658; F: (512) 305-8101

Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.texas.gov
Katherine A. Thomas, MN, RN, FAAN
Executive Director

November 20, 2020

Srinivas Behara, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Electronic Filing

Re: In the Matter of Permanent Certificate No. RN 236013
Issued to: **CINDY FARRELL TOW**
SOAH Docket No. **507-20-3473**

Dear Judge Behara:

Enclosed please find ***Staff's Response to Respondent's Exceptions to the PFD***, regarding the above-entitled cause.

By copy of this letter, I am forwarding a copy of same to the Respondent's counsel.

Thank you for your time and assistance with this case.

Very truly yours,

Jacqueline A. Strashun
Assistant General Counsel

JAS/man
Enclosure

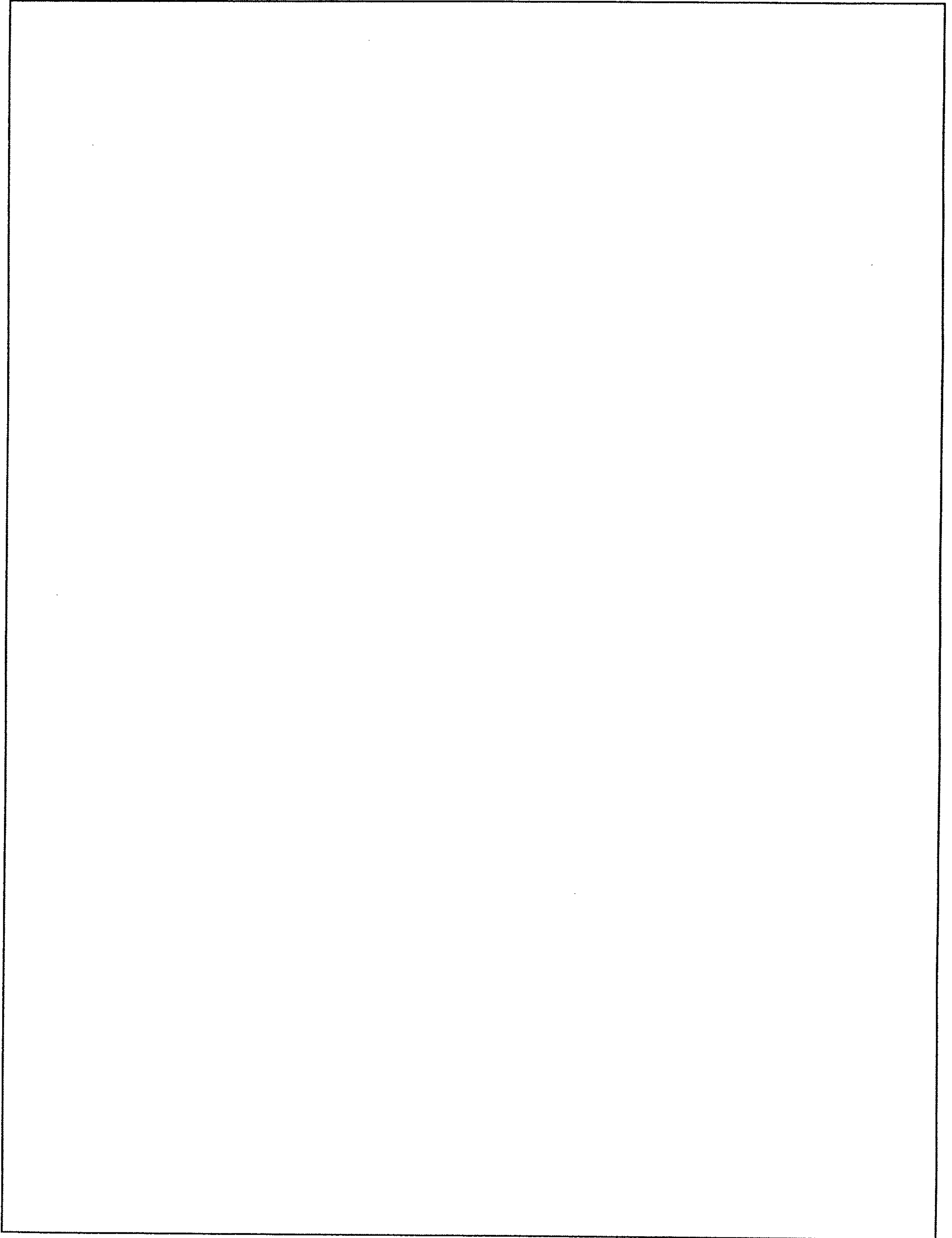
Kathleen Shipp, MSN, RN, FNP
Lubbock, *President*

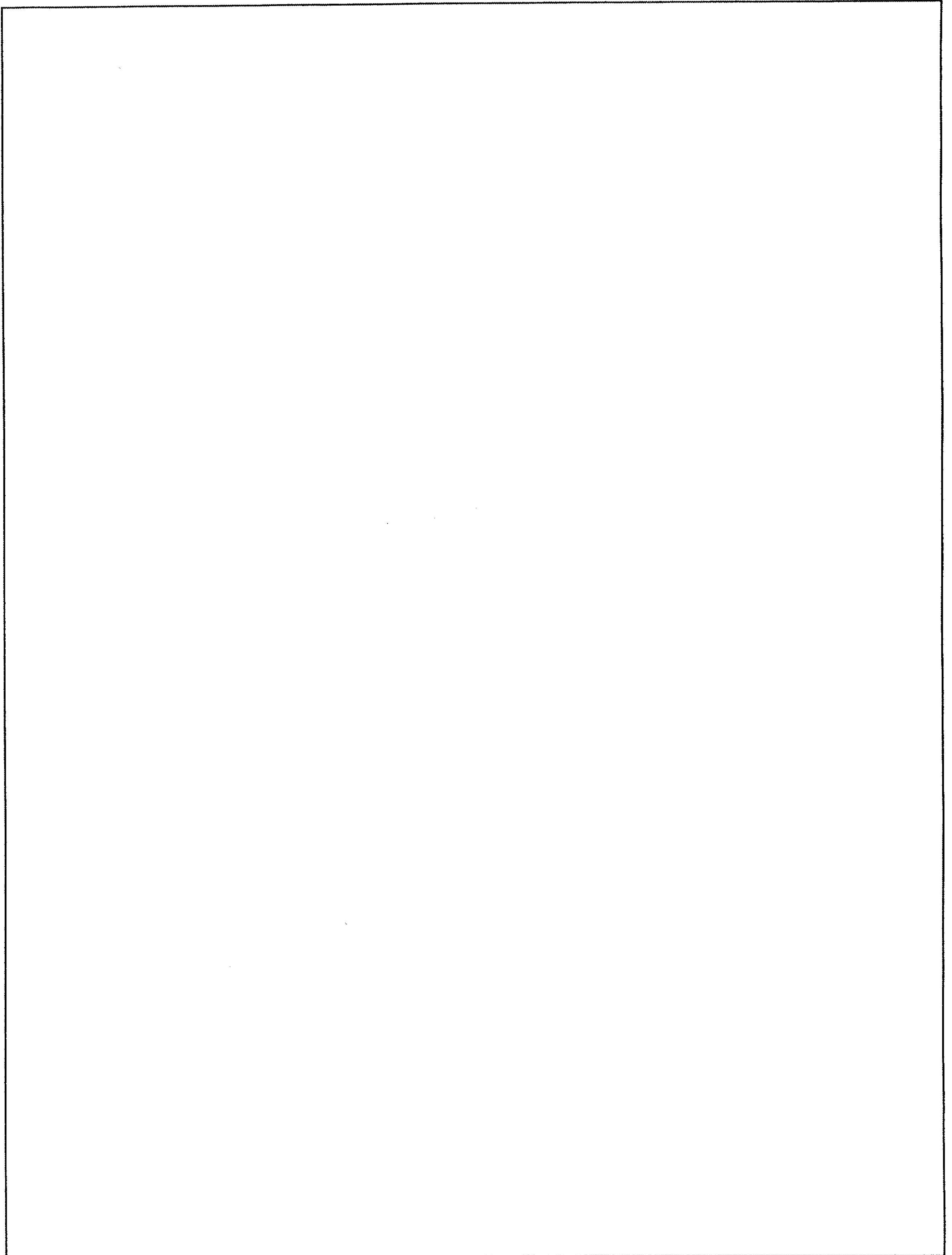
David Saucedo, II
El Paso, *Vice-President*

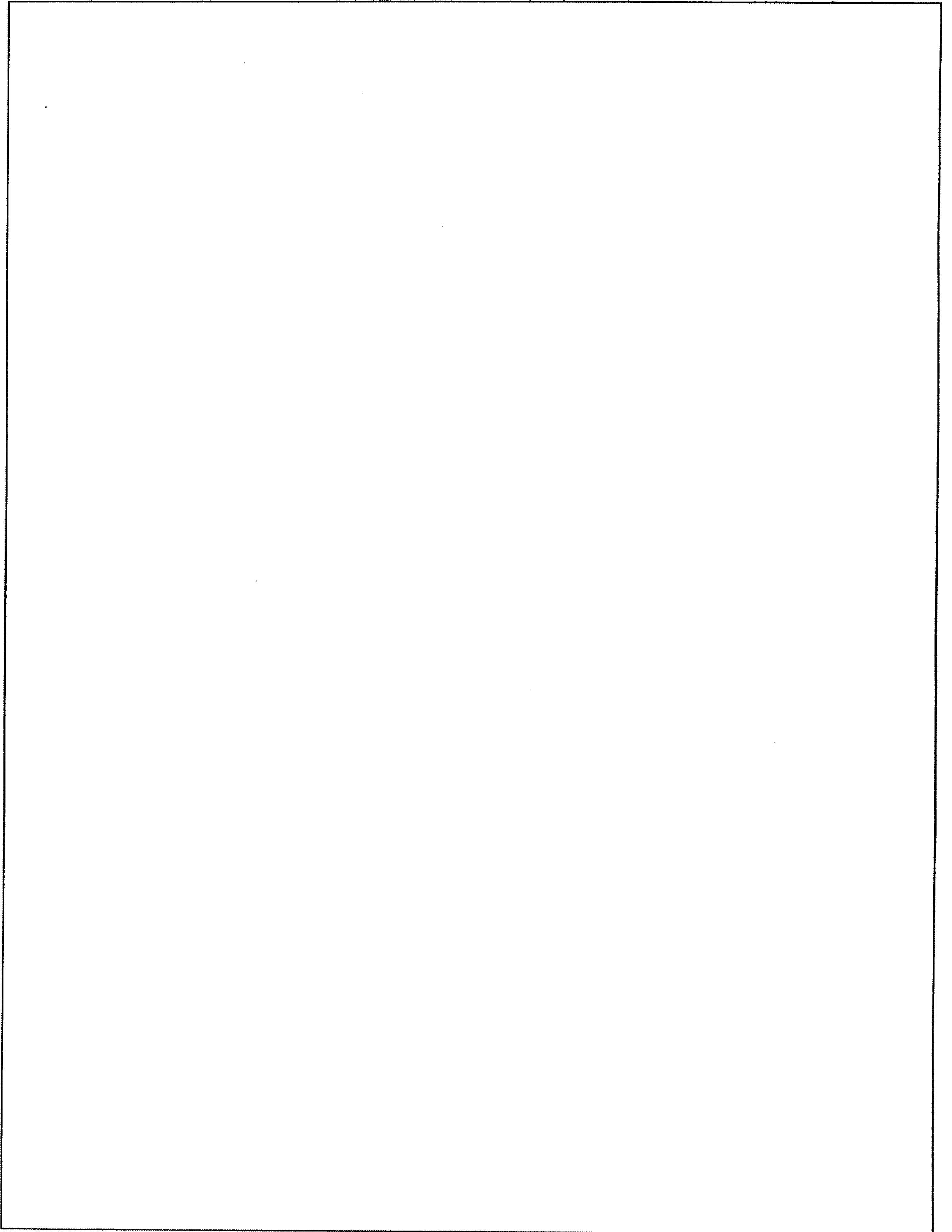
SOAH DOCKET NO. **507-20-3473**

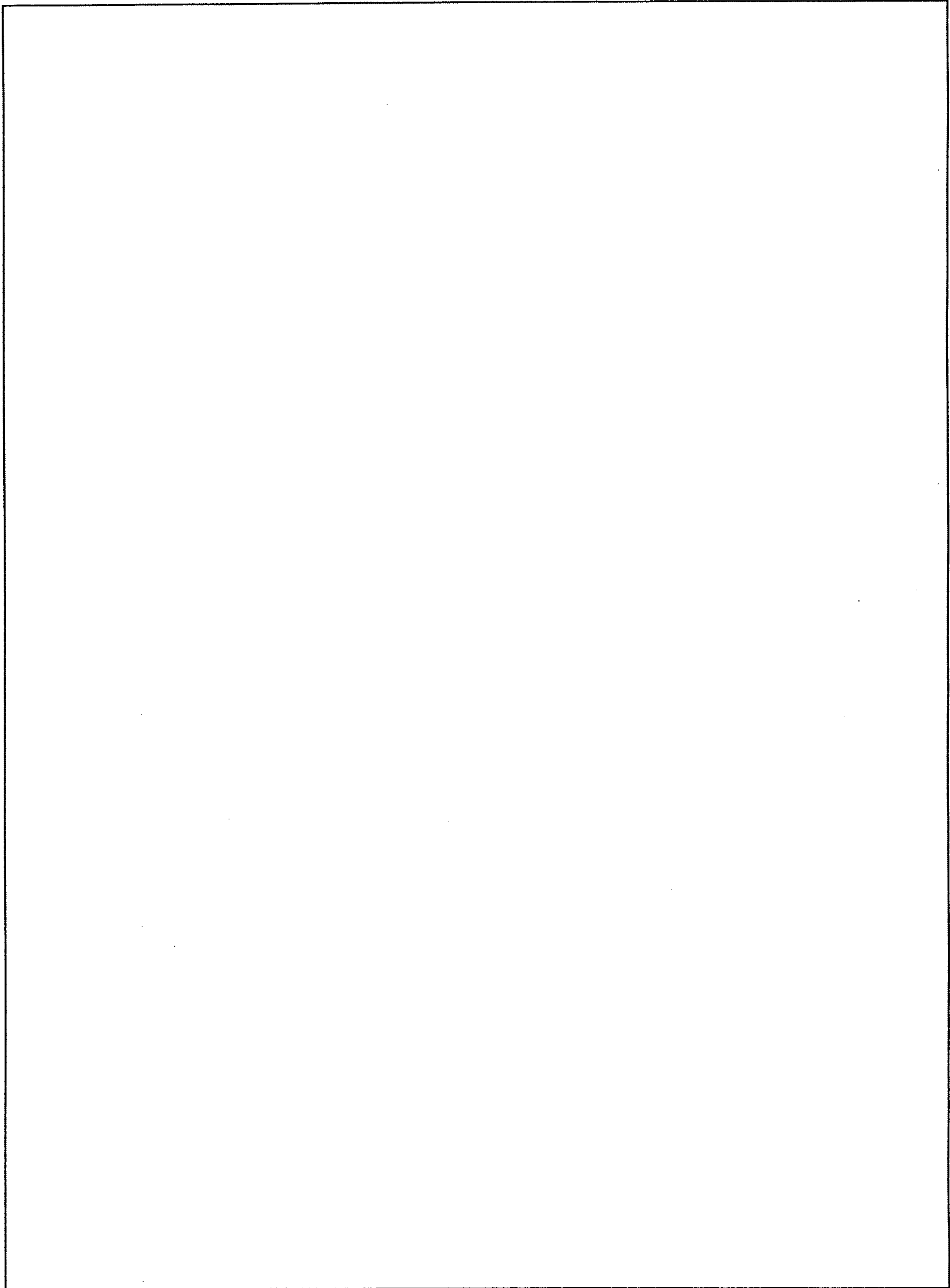
IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 236013	§	OF
ISSUED TO	§	
CINDY FARRELL TOW	§	ADMINISTRATIVE HEARINGS

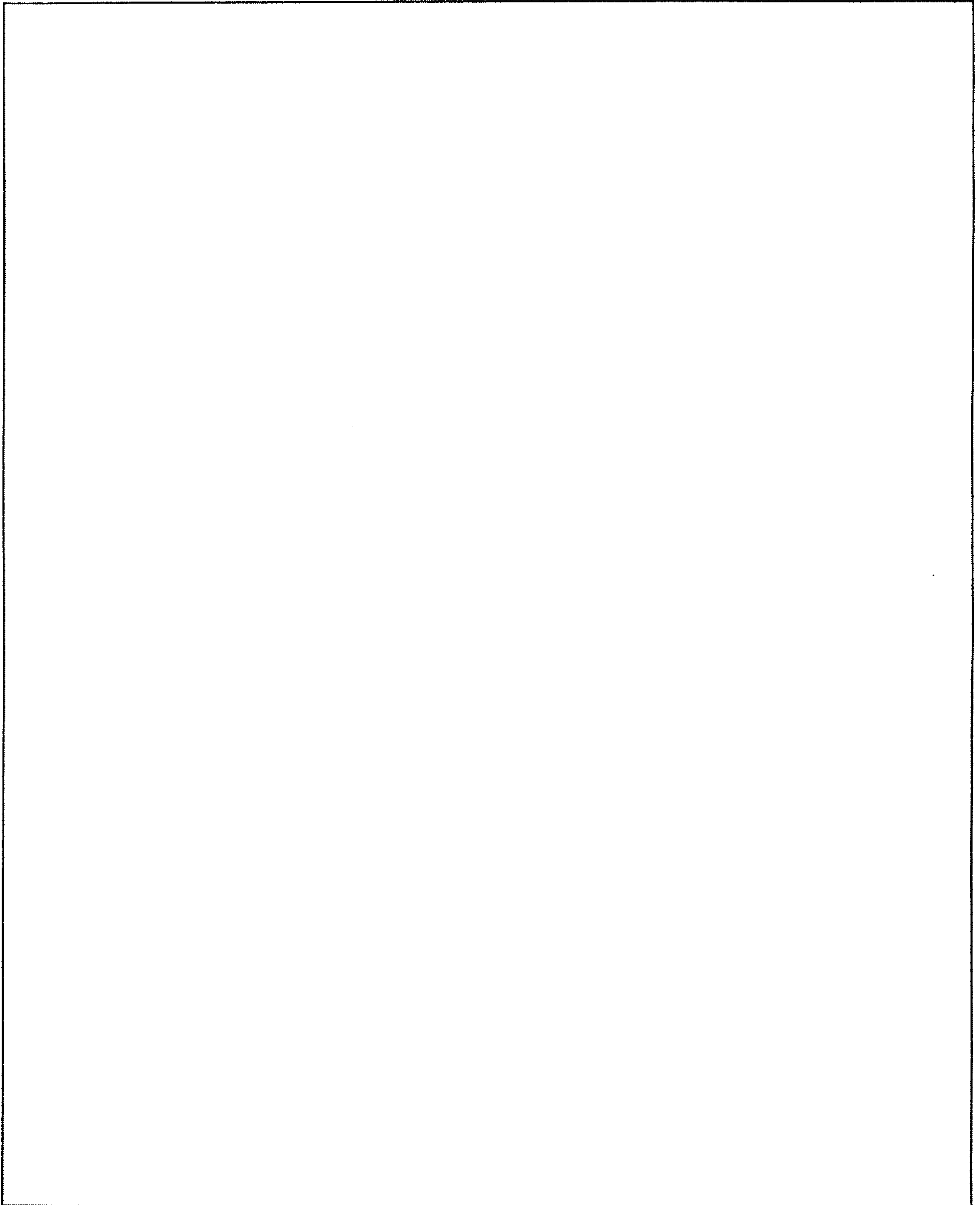
STAFF'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

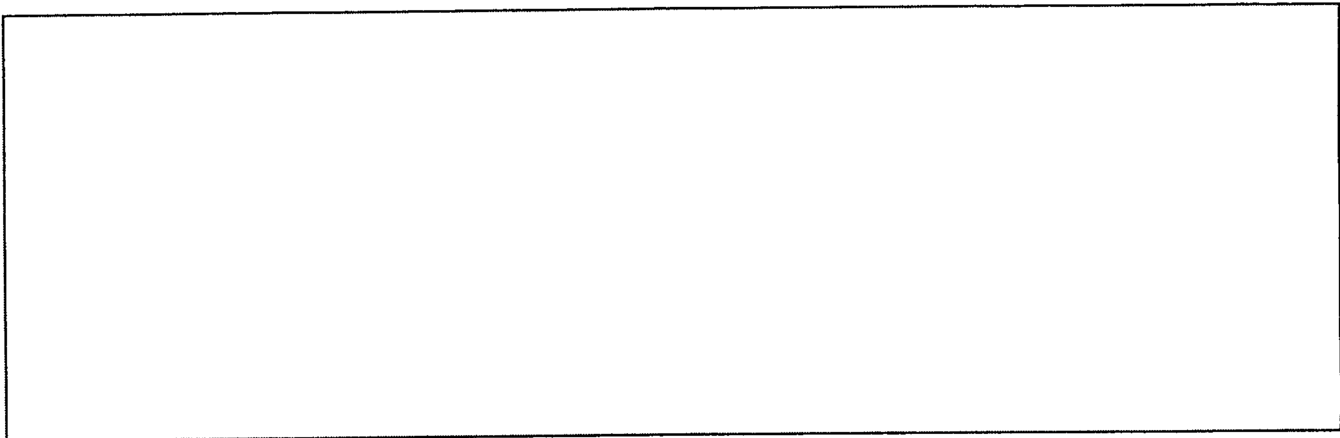












Respectfully Submitted,

TEXAS BOARD OF NURSING

Jacqueline A. Strashun, Assistant General Counsel
State Bar No. 19358600
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Austin, Texas 78701
P: (512) 305-7658; F: (512) 305-8101

CINDY FARREL TOW. SOAH DOCKET No. 507-20-3473

CERTIFICATE OF SERVICE

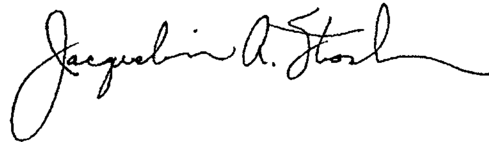
I hereby certify that a true and correct copy of the foregoing ***Staff's Response to Respondent Exceptions to PFD*** was sent via E-mail and First Class Mail on November 20, 2020 to:

State Office of Administrative Hearings — Filed electronically

And

Marc M. Meyer, RN, JD
Law Office of Marc Meyer, PLLC
525 Woodland Square Blvd., Ste. 250
Conroe, TX 77384

via E-mail: marc@marcmeyerlawfirm.com



Jacqueline A. Strashun, Assistant General Counsel

ACCEPTED
507-20-3473
12/28/2020 11:23 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK

FILED
507-20-3473
12/28/2020 10:39 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

December 28, 2020

VIA E-FILE 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. 507-20-3473; Texas Board of Nursing v. Cindy Tow

Dear Ms. Thomas:

On October 22, 2020, a Proposal for Decision (PFD) was issued in this matter. On November 6, 2020, Respondent filed exceptions to the PFD. Staff for the Texas Board of Nursing filed a response to the exceptions on November 20, 2020.

Respondent filed exceptions to Findings of Fact Nos. 16, 17, 19, 20, 22, and 24, based on the argument that the findings are not supported by the evidence. Respondent further filed exceptions to Conclusions of Law Nos. 5 and 6, which correspond to the above Findings of Fact subjecting Respondent to sanctions. Specifically, Respondent argues that all six Findings of Fact are premised on the testimony of Dr. Drushti Dave regarding a printout of pump operations that was alleged to have been from the pump in question. Respondent argues Dr. Dave's testimony should have been given little to no weight because she was not the individual who ran the history on the pump, and the individual or entity that ran the pump history was not called to testify. However, as discussed on pages 6-7 of the PFD, Dr. Dave credibly testified that she verified the pump history by confirming it was the correct pump. She also compared the pump history to the patient's medical records and pharmacy records and Respondent's infusion records from the IVIGs on March 5, 2016, and April 2, 2016. There was no evidence to dispute Dr. Dave's testimony that the pump history was ran on the correct pump. Dr. Dave further testified that the pump in question, the Curlin 6000, was extremely reliable because it continually records and saves all pump event data for the life of the pump. Based on the credible evidence presented, Respondent's exceptions are respectfully denied.

Respondent further requests that the recommended sanction be adjusted for the Board to order a lower level of supervision, incident reporting, which does not require the Respondent to be employed in an institutional setting, but only requires that any issues with Respondent's practice be reported to the Board. The Board has the ultimate authority to fashion disciplinary sanctions that fit the misconduct at issue and that will protect the public. Given the latitude the

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State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

December 28, 2020

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

VIA E-FILE TEXAS

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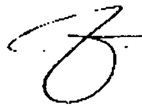
Board may exercise in disciplinary matters, the ALJ is not persuaded that the sanction set forth in the PFD is inappropriate for consideration by the Board. The ALJ's recommendation is based on his findings of fact, including Finding of Fact No. 31. Accordingly, Respondent's request to change the recommended sanction is denied, and the PFD is ready to be presented to the Board for a final decision.

Regards,



Srinivas Behara
Administrative Law Judge

VB/jh
Attachment

xc: Jacqueline A. Strashun, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA E-FILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD of Hearing on the Merits) – **VIA E-FILE TEXAS and INTERAGENCY MAIL**
Marc M. Meyer, Marc Meyer Law Firm, 525 Woodland Square Blvd., Suite 250, Conroe, TX 77384-2212 - **VIA E-FILE TEXAS**