DOCKET NUMBER 507-20-2433

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 326454 ISSUED TO CHRISTIANA A. AKANBI	**§**	**BEFORE THE STATE OF ADMINISTRATIVE HE**

OPINION AND ORDER OF THE BOARD

TO: CHRISTIANA A. AKANBI
C/O LURESE TERRELL, ATTORNEY
KENNEDY ATTORNEYS AND
COUNSELORS AT LAW
12222 MERIT DRIVE, SUITE 1750
DALLAS, TX 75251

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

At the regularly scheduled public meeting on October 21, 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; the ALJ's final letter ruling dated August 20, 2021; 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 July 29, 2021. On August 20, 2021, the ALJ issued a final letter ruling, in which she declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; Respondent's exceptions to the PFD; the ALJ's final letter ruling dated August 20, 2021; 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, and the Board agrees, that the Respondent's conduct warrants a second tier, sanction level II sanction for her violation of §301.452(b)(10) & (13)[1]. Either licensure suspension or licensure revocation is authorized by the Board's Disciplinary Matrix for a second tier, sanction level II sanction of §301.452(b)(10) and (13)[2]. The Board agrees with the ALJ that a two year probated suspension with stipulations is the most appropriate sanction in this matter.

The Respondent's conduct was serious and placed an extremely vulnerable pediatric patient at risk of harm[3]. Further, the Respondent committed multiple violations of the Board's rules[4]. The ALJ found mitigating factors, as well. The Respondent has no disciplinary history with the Board; has good subsequent work history; returned to school and obtained an RN degree and RN licensure in Florida; and completed two remedial education courses[5].

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 two year probated suspension 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 critical thinking course, a physical assessment course; and a documentation course[6]. While the Board notes that the Respondent completed two remedial education courses in documentation standards and nursing jurisprudence and ethics, these courses are shorter in duration and do not contain the same content as the courses the Board typically imposes as part of its disciplinary orders. As such, the Board finds that the Respondent should complete the specific courses related to documentation and nursing jurisprudence and ethics specified in this order. The Board also agrees with the ALJ that the Respondent's nursing practice should be supervised. Specifically, the Board finds that

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[1] See adopted Conclusion of Law Number 12.

[2] See §213.33(b).

[3] See adopted Findings of Fact Numbers 37 and 38.

[4] See adopted Finding of Fact 39.

[5] See adopted Findings of Fact Numbers 40-46.

[6] 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.

the Respondent's practice should be directly supervised for the first year of the order and indirectly supervised for the remainder 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. These stipulations are consistent with 22 Tex. Admin. Code §213.33(e)(6)[7].

IT IS THEREFORE ORDERED that Vocational Nurse License Number 326454, previously issued to CHRISTIANA A. AKANBI, to practice nursing in the State of Texas is hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

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

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

C. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

D. 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. 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"

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[7] 22 Tex. Admin. Code §213.33(e)(6), which authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

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 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. **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.

C. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

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.*

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 eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed

Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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

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

V. FURTHER COMPLAINTS

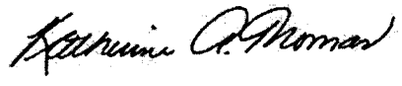
If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

VI. 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 October, 2021.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; 507-20-2433 (July 19, 2021)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

July 19, 2021

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. 507-20-2433; Texas Board of Nursing v. Christiana A. Akanbi

Dear Ms. Thomas:

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

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

Sincerely,

Sarah Starnes

Sarah Starnes
Administrative Law Judge

SS/tt

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA EFILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 (with 1 CD of Hearing on the Merits) – **VIA EFILE TEXAS & INTERAGENCY MAIL**
Lurese Terrell, Kennedy Attorneys and Counselors at Law, 12222 Merit Drive, Suite 1750, Dallas, TX 75251 - **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-20-2433

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
CHRISTIANA A. AKANBI, LVN, Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-20-2433

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
CHRISTIANA A. AKANBI, LVN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against the licensed vocational nurse (LVN) credential held by Christiana A. Akanbi (Respondent) based on alleged deficiencies in her care of a pediatric patient (Patient) who died while Respondent was providing her in-home care. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove most of the allegations in its three charges. The ALJ recommends that the Board impose a two-year probated suspension with educational requirements, workplace supervision restrictions, and other 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. On April 21, 2021, ALJ Sarah Starnes convened the hearing via Zoom videoconference before the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel John Vanderford represented Staff, and attorney Lurese A. Terrell represented Respondent. The record closed on May 24, 2021, after the parties filed their written closing arguments.

II. APPLICABLE LAW

The Texas Nursing Practice Act (Act), found in chapter 301 of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, failure to meet minimum standards of nursing practice (pursuant to Code § 301.452(b)(13)) or unprofessional conduct (under Code § 301.452(b)(10)). Staff asserts that Respondent's conduct is grounds for

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

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

- **Board Rule 217.11(1)(A)**: Failure to know and conform to the Act and Board rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of practice;
- **Board Rule 217.11(1)(B)**: Failure to implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(D)**: Failure to accurately and completely report and document required matters, including client status, nursing care rendered, administration of medications and treatments, and client responses;
- **Board Rule 217.11(1)(G)**: Failure to obtain instruction and supervision as necessary when implementing nursing procedures or practices;
- **Board Rule 217.11(1)(M)**: Failure to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications; and
- **Board Rule 217.11(1)(P)**: Failure to collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care.

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

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;

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[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 ____."

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

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

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

When a nurse has violated the Code or Board rules, the Board is required to impose a disciplinary sanction.[3] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[4] The Disciplinary Matrix categorizes violations into tiers, and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. The Disciplinary Matrix also lists certain aggravating and mitigating factors that must be considered. Board Rule 213.33 includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[5]

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

III. EVIDENCE

Staff had seven exhibits admitted into evidence and presented testimony from Respondent and from Linda Laws, a registered nurse (RN) who is a nursing practice consultant to the Board. Respondent had five exhibits admitted into evidence and testified on her own behalf.

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

[4] Board Rule 213.33(b).

[5] Board Rule 213.33(c).

[6] 1 Tex. Admin. Code § 155.427.

A. Background[7]

Respondent has been licensed as a vocational nurse in Texas since June 2015.[8] Shortly after receiving her license, she began working for Viva Pediatrics, a home-health agency. Beginning in or about 2016, Respondent was assigned as a weekend nurse providing in-home care for Patient, a pediatric patient with leukodystrophy and white matter disease, which are rare metabolic, genetic diseases that progressively destroy the brain's tissue.[9] Patient was not able to feed herself, move, or speak, and she also had a seizure disorder, among other diagnoses. Patient's sibling had the same conditions. Both children had in-home nurses during the day, and their parents cared for them overnight. Typically, Respondent worked twelve-hour shifts, from 6:00 a.m. to 6:00 p.m. on Fridays and Saturdays. She also sometimes worked shifts on other days as needed (prn). This case involves several shifts that Respondent worked with Patient in February 2017.

On February 6, 2017, a day Respondent was not working, Patient was taken to the emergency room (ER) and treated for an upper respiratory infection. The ER physician determined that the infection was viral, not bacterial, and did not prescribe any antibiotics. The discharge orders directed that Patient should be given supplemental oxygen if her oxygen saturation levels declined and specified that she could use her sibling's oxygen until Patient had her own supply. Specifically, the order stated:

> If needed at home, she may use O2 at 1-2L as needed for Oxygen saturation less than 90%. Pulmonary clinic will arrange for home O2 for [Patient] but for the time being, she can use her sister's O2 until these arrangements have been made.[10]

On Friday, February 10, 2017, Respondent arrived for her shift and learned from the RN caring for Patient's sibling that Patient had been to the ER several days before. Respondent referred to Patient's plan of care and saw that the weekday nurse had recorded the order for supplemental

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

[8] Staff Ex. 1.

[9] Patient's age is not in evidence, but her medical records refer to diagnoses made in February 2007, making her at least 10 years old when the events at issue occurred.

[10] Resp. Ex. 7. Patient's sibling also sometimes used supplemental oxygen.

oxygen, and she then called the nurse and Patient's mother for more information. The nurse and Patient's mother told Respondent that Patient was still using her sister's oxygen when needed because they had not yet received Patient's own supply. Respondent did not call Viva Pediatrics to report that oxygen was needed that day or during her shift the following day. When she worked her shifts the following weekend (February 16-18), Patient was still relying on her sister's oxygen supply, and Respondent did not report this to Viva Pediatrics. In Charge I in the Formal Charges, Staff contends that Respondent's failure to notify her supervisors at Viva Pediatrics that Patient's oxygen had not been delivered was likely to injure the patient.

Patient's feedings were administered enterally through a gastronomy button. Prior to a feeding, Patient's gastric residual volumes had to be assessed to ensure that she had digested the previous feeding. If her stomach was still full of fluid or gas, Patient could aspirate, or breathe the fluid into her lungs. In Charge II in the Formal Charges, Staff contends that during her shift on February 18, Respondent failed to assess or document Patient's gastric residual volumes prior to administering feedings.

Charge III in the Formal Charges also addresses Respondent's shift on February 18. When Respondent arrived for her shift at 6:00 a.m., she found that Patient's mother had begun administering supplemental oxygen overnight. According to Respondent's nursing notes, even though Patient was receiving one liter/minute (1L/min) of oxygen, her oxygen saturation level was only at 92%. Her pulse rate was also elevated above her normal level. Respondent later noticed that Patient's oxygen saturation had fallen to 85% at about 10:30 a.m.[11] Despite increasing the rate of supplemental oxygen to 2L/min (the maximum rate allowed by the ER doctor's order), Patient's oxygen saturation continued to fall, and she went into cardiac arrest. Respondent called 911, and CPR was administered, but Patient did not survive. Staff alleges that Respondent should have, but failed to, promptly notify her RN supervisor or Patient's physician about changes in her respiratory status that morning, and that Respondent's inaction may have deprived Patient of needed medical interventions.

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[11] Staff Ex. 6 at 2. As discussed below, Respondent's nursing notes are internally inconsistent with respect to the timing of events during her shift that morning.

B. Respondent's Testimony

1. Charge I: Failure to Report Need for Oxygen

Respondent testified that she first learned of Patient's ER visit and the order for supplemental oxygen when she arrived for her shift on Friday, February 10, 2017. She reviewed Patient's plan of care and also spoke directly to the weekday nurse who had recorded the ER order, and the other nurse told her that she had already reported to Viva Pediatrics that Patient needed oxygen and was using her sister's supply in the meantime. That is why, Respondent explained, she did not report the need for oxygen during her shifts that weekend.

Patient still did not have her own oxygen supply when Respondent returned for her shifts the following week, on February 16, 17, and 18, 2017. Respondent testified that she was concerned because she knew that Patient's sister, who was even more fragile than Patient, might also need to use supplemental oxygen, and Respondent feared they would not have enough for both patients. On Friday, Respondent expressed this concern to Patient's mother, and she testified that the mother immediately called the equipment company to inquire about Patient's oxygen order.

According to Respondent, Patient's mother usually insisted on obtaining her children's medications and equipment herself. Respondent would tell her what Patient needed, and the mother would promptly obtain it. Respondent acknowledged that, as the nurse, it was ultimately her responsibility to make sure her patient had the medication she needed. Still, under the circumstances, she believed at the time she could rely on the mother's assurance that she would get the oxygen. She did not report to Viva Pediatrics during any of her shifts on February 16-18, 2017, that Patient still needed her own oxygen supply.

Respondent testified that, if the same situation occurred today, she would know to tell her supervisor that her patient did not have her own oxygen. Had she done so, Viva Pediatrics could have followed up with Patient's mother to reiterate how important it was to have oxygen in the home for Patient.

2. Charge II: Failure to Assess or Document Gastric Residual Volumes

In her testimony, Respondent described how she prepared and administered feedings to Patient. She said Patient would receive four or five feedings a day, with each feeding administered in two parts, approximately thirty minutes apart. Respondent testified that she checked Patient's gastric residual volumes before every feeding and vented her to remove any excess gas from the stomach and tube. Respondent understood this was necessary to ensure Patient had digested her previous meal, so that her stomach was empty for the next feeding. She said checking gastric volumes had been part of her everyday care for Patient since 2016, and Patient tolerated her feedings well. However, Respondent admitted it was not her practice at the time to document these checks, and she did not dispute Staff's allegation that she had not documented Patient's gastric residual volumes in her nursing notes on February 18, 2017. She said she now knows to document everything she does for a patient and understands it is important to leave a complete record for her patients' subsequent caregivers.

3. Charge III: Failure to Report Change in Patient's Respiratory Status

Respondent testified that Patient's normal oxygen saturation level was around 96-98%, and that in her experience it was unusual for Patient's oxygen saturation to fall to the low 90s or high 80s. Until Patient's viral infection in February, she had never needed a pulse oximeter or supplemental oxygen.

Respondent's nursing notes show that when she began her shift at 6:00 a.m. on Friday, February 17, 2017, Patient's oxygen saturation rate was 92% on room air, meaning Patient was not using supplemental oxygen at that time.[12] Respondent's notes, which described Patient's status and referenced a discussion with the mother at the start of the shift, do not indicate that Patient had needed oxygen overnight, either. Respondent noted that Patient's lungs seemed congested at the start of the shift, but after receiving medication and being repositioned, Patient was reassessed at

[12] Staff Ex. 6 at 5.

6:30 a.m. and her "congestion seem[ed] good."[13] Respondent testified that wheezing and congestion were not uncommon for Patient, even prior to her February infection, and Patient's plan of care directed the nurse to suction and administer breathing treatments as needed.[14] Later that morning, Patient's oxygen saturation dropped to 87%, which prompted Respondent to administer supplemental oxygen pursuant to the ER physician's order. Respondent testified that Patient responded to that treatment and her oxygen level went back up to 90-92%, the range that had been normal for her since the ER visit the previous week.

Respondent called Patient's parents and advised them that she did not think Patient was well enough to go to school that day.[15] Afterwards, Patient's oxygen saturation continued to fluctuate but stayed above 90%. By mid-afternoon, Respondent wrote that Patient's oxygen saturation "seems stable [at] 97%."[16] Respondent testified that she was not overly concerned by Patient's fluctuating oxygen levels because she knew Patient had been fighting a viral infection and seemed to be responding to her treatments, including the supplemental oxygen ordered by the ER physician the previous week. She said she knew to call Patient's physician or her RN supervisor if she saw any signs of distress, but none were observed that Friday. She was also comfortable asking questions of the RN who was working with Patient's sister, in the same room.

The next day, Respondent recorded that Patient's oxygen saturation was at 90% when her shift began at 6:00 a.m., and that Patient was receiving 1L/min of supplemental oxygen, which her mother had started overnight.[17] Patient's pulse was also elevated over her usual levels, according to Respondent. Pressed on whether she interpreted these readings as a sign that Patient's condition had declined since the previous day, Respondent said she was "concerned" but noted that Patient's temperature was normal and she was not exhibiting any signs of distress, so Respondent did not see a reason to call her supervisor or Patient's physician. Respondent also knew from experience

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[13] Staff Ex. 6 at 6.

[14] Staff Ex. 6 at 16.

[15] Staff Ex. 6 at 6. Respondent testified that Patient and her sister both attended school, accompanied by their nurses to assist them.

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

[17] Staff Ex. 6 at 2-3.

that Patient tended to have a lot of secretions and that her pulse usually improved after suctioning. Respondent said she assessed Patient, reduced the oxygen volume, then suctioned Patient, administered a feeding and a breathing treatment,[18] and performed oral care. After this, according to her notes, Patient's pulse lowered and her oxygen saturation increased to 96%.[19] Respondent testified that the patient's oxygen saturation continued to fluctuate all morning.

In her notes, Respondent wrote that she administered another feeding to Patient at about 10:30 a.m., and she testified that she was in the kitchen preparing the second half of the feeding when she heard Patient's pulse oximeter begin to alarm.[20] Her notes state that at approximately 11:10 a.m., Patient's oxygen saturation had decreased to 88%, which prompted Respondent to increase the rate of supplemental oxygen to 2L/min. Though she had previously responded to increasing the oxygen volume, this time Patient continued to desaturate and her oxygen saturation level fell to 78%. Respondent said she immediately recognized that the situation was an emergency and there was no time to call Patient's physician or her supervisor. Instead she told the other nurse present (the sister's nurse) to call 911 and, realizing Patient was in cardiac arrest, they administered CPR until paramedics arrived and took over.[21] Respondent then called her agency and Patient's parents, and she followed Patient's ambulance to the hospital in her own car. Patient could not be revived and was pronounced dead at the hospital.

Elsewhere in her notes, Respondent recorded that Patient's oxygen saturation had dropped to 85% at 10:30 a.m., approximately 40 minutes earlier than her narrative notes indicated.[22] At the hearing she explained that the notes were made later that day, several hours after Patient's death. She said the sequence of events described was accurate even if there were minor discrepancies in

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[18] Breathing treatments and suctioning were part of Patient's routine daily care, according to Respondent, unrelated to the viral infection she came down with in February.

[19] Staff Ex. 6 at 3.

[20] Respondent's notes indicate that she administered a 130 milliliter (mL) feeding at 10:30 a.m. Staff Ex. 6 at 3. At the hearing, Respondent clarified that the full feeding would have been 130 mL, but that she only administered the first half (65 mL) and was preparing the second half when Patient desaturated. She acknowledged that her notes were inaccurate to the extent they reflect the full feeding was completed.

[21] Staff Ex. 6 at 3-4.

[22] Staff Ex. 6 at 3.

the times recorded, which she generally attributed to the chaos and stress of the morning's events. She said she was upset and "not myself" when she returned to Patient's home to gather her things and complete her notes.

In the wake of this incident, Respondent testified, she now understands that she must communicate more forcefully and directly with her patients' doctors to relay what she knows about a patient's condition.

4. Other Evidence

Respondent defended her nursing practice and explained that she did the best she could in a difficult situation. She testified that home health is a particularly challenging work environment and she was called on to manage Patient's parents' expectations and directions, which did not always align with those of Viva Pediatrics or the physician's orders. She also said "there is no way we can avoid making little mistakes" in the nursing notes, which she has to make during her shift while caring for her patient.

Respondent has worked consistently as a nurse since Patient's death and continues to work in pediatric home health.[23] Her exhibits include a letter from the Nurse Director of Vigor Care Pediatric Services who wrote that Respondent has been an "employee in good standing" since October 2017, and provides good care and turns in timely and proper documentation.[24]

Respondent also returned to school and took classes from the Essential School of Nursing in Miami, Florida in 2019 and 2020.[25] She testified that she is now licensed as an RN in Florida but has not yet taken the exams required to obtain an RN license in Texas. She has also completed continuing education classes in Texas, including a two-hour Texas Nursing Jurisprudence and Ethics course in April 2020, and a two-hour course on making accurate and legal documentation

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[23] Resp. Ex. 2.

[24] Resp. Ex. 3.

[25] Resp. Ex. 5.

in July 2017.[26] With the experience and education she has gained since 2017, Respondent said she has matured and improved as a nurse.

C. Ms. Laws's Testimony

Ms. Laws has been a licensed RN since 1977 and has been a Nursing Practice Consultant for the Board for over eight years. She testified as an expert on the Board's laws and rules. Having reviewed the medical records in evidence for Patient, Ms. Laws offered opinions on the alleged violations and appropriate sanction.

1. Charge I: Failure to Report Need for Oxygen

Ms. Laws testified that it is a nurse's responsibility to advocate for her patients' safety and ensure emergency equipment is available. In this case, that duty required Respondent to collaborate with the other members of Patient's health-care team to ensure she had supplemental oxygen at home after the ER physician had ordered it on February 6, 2017. Ms. Laws said Respondent was required to either call her supervisor to inquire about the oxygen or to directly call an oxygen supplier. She was particularly concerned that Respondent had not called her RN supervisor about the need for oxygen during her shifts beginning on February 16, 2017, the second weekend after it had been prescribed in the ER. Respondent should not have relied on the mother's assurance that she would get the oxygen, according to Ms. Laws, because the nurse's duty to her patient cannot be superseded by facility policy or directives from family members.

In Ms. Laws's opinion, it was not appropriate to rely on Patient's sister's oxygen supply because "if the other child needed the oxygen, there was not going to be enough of it." However, she conceded there is no indication in the medical records that they ever ran low on oxygen in Patient's home.

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[26] Resp. Ex. 4.

2. Charge II: Failure to Assess or Document Gastric Residual Volumes

Patient's medical records indicate a history of constipation and reflux, which made it particularly important to check and document her gastric residual volumes before every feeding, according to Ms. Laws. The checks were important to gauge how Patient's gastrointestinal system was functioning because Patient was at risk of aspirating if a feeding were given when her stomach was not empty. It was important to document the checks so that the next person to care for Patient would know if there had been a problem at prior feedings or if a pattern of residual volumes was emerging.

Ms. Laws opined that, had Respondent checked Patient's residual volumes, she would have documented it. Ms. Laws said there is nothing in the medical records to corroborate Respondent's testimony that she always checked Patient's gastric residual volumes before a feeding.

3. Charge III: Failure to Report Change in Patient's Respiratory Status

Ms. Laws explained that LVNs like Respondent have a directed scope of practice, which means they must be supervised by an RN, physician, or other practitioner. RNs, by contrast, are able to work autonomously. LVNs are able to perform focused assessments that examine only a certain aspect of the body, while RNs can perform comprehensive, head-to-toe, patient assessments. Because of the limitations on an LVN's practice, it is important for an LVN who observes any changes in her patient to report them to her RN supervisor so the RN can evaluate the changes in the context of a comprehensive assessment.

Ms. Laws identified several times on February 17-18, 2017, when Respondent noted changes in Patient's condition that, in Ms. Laws's opinion, should have prompted a report to Respondent's RN supervisor or Patient's primary care physician. She pointed out that Patient's plan of care, which was prepared in January 2017, included an order to notify Patient's physician of any signs or symptoms of respiratory distress or infection.[27] This order was not superseded by

[27] Staff Ex. 6 at 16.

the ER physician's February 6, 2017 order for supplemental oxygen when needed, according to Ms. Laws.

At the start of her shift on February 17, 2017, Respondent's notes state that she performed an assessment and Patient's "lungs seem[ed] congested."[28] Ms. Laws testified that this represented a change in condition Respondent was required to report to her supervisor, and she fell below the standard of care in failing to do so. Another opportunity to call her supervisor came later that morning, when Respondent's notes show Patient's oxygen saturation dropped to 87% at 9:30 a.m., which prompted her to give supplemental oxygen at a rate of 2L/min. Respondent then called Patient's parents to alert them that Patient was not well enough to attend school that day, but she should have also notified her RN supervisor, according to Ms. Laws. Respondent had administered oxygen at the maximum rate allowed by the ER physician's order and should have recognized a need to collaborate with her supervisor on a plan for how to proceed if the patient's oxygen saturation continued decreasing. Ms. Laws also testified that Respondent should have notified her supervisor when she gave another nebulizer treatment and suctioning between 10:00 and 10:30 a.m. The medical records indicate that Patient had not needed supplemental oxygen for at least four days preceding Respondent's February 17, 2017 shift.[29] Her fluctuating oxygen saturation levels that morning, and the need for other breathing treatments, should have prompted Respondent to question why Patient's condition had changed and to discuss with her RN what could be going on. She also could have called Patient's physician, Ms. Laws asserted.

Patient's condition at the start of Respondent's shift on February 18, 2017, should have also prompted a call to the RN supervisor, according to Ms. Laws. That morning, Patient was already on supplemental oxygen when Respondent's shift began at 6:00 a.m., unlike the previous day, and Respondent's initial assessment reflected that Patient's pulse had increased over the day before. Both developments were concerning, Ms. Laws testified, and Respondent should have known that a full assessment by the RN was needed to understand physiologically why Patient's

[28] Staff Ex. 6 at 6.

[29] Staff Ex. 6 at 13.

condition had changed since the previous morning. She emphasized that an increased respiratory demand can increase the pulse, and the respiratory status of a sick child can decline very quickly.

Ms. Laws also testified that Respondent should have called her RN supervisor between 10:30 a.m. (when the notes indicate in one place that Patient's oxygen saturation was at 85% while on 2L/min of supplemental oxygen) and 11:10 a.m. (when the narrative notes state that Patient's oxygen saturation fell to 88% and kept decreasing after her supplemental oxygen was increased to 2L/min). Ms. Laws interpreted Respondent's notes to mean that she administered a feeding between those two oxygen saturation readings, which Ms. Laws considered dangerous. Had Respondent given an enteral feeding while Patient's oxygen saturation was so low, she would have been at high risk of aspirating, which could cause further desaturation, according to Ms. Laws.[30] She said it was very concerning that Respondent never recognized a need to call her RN supervisor or Patient's physician about her change in condition prior to Patient's cardiac arrest.

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

IV. ANALYSIS

A. Charge I: Failure to Report Need for Oxygen

For Charge I, Staff alleges that Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to report to her supervising RN or Viva Pediatrics administrators that the supplemental oxygen prescribed for Patient had not been delivered to Patient's home.

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[30] Ms. Laws also conceded that there is nothing in the medical records—either in Respondent's notes or in the records in evidence from Cook Children's Medical Center, where Patient was taken by ambulance—indicating that Patient aspirated a feeding before she died.

The supplemental oxygen was prescribed on February 6, 2017, and entered into Patient's medical record the same date. The ER physician noted that Patient could use her sister's oxygen supply "for the time being," until arrangements had been made for her own supply.[31] Subsequently, Respondent worked on shifts on February 10, 11, 16, 17, and 18, 2017, and it is undisputed that Patient did not have her own oxygen supply at home on any of those dates. Respondent testified that she did not raise the issue the first weekend (February 10-11) because the weekday nurse told her in their phone call that she had already let Viva Pediatrics know that Patient was waiting on oxygen supplies. And Respondent testified that the following weekend she raised the matter directly with Patient's mother, who then called the equipment supplier. However, Ms. Laws testified, and Respondent acknowledged, that a nurse is ultimately responsible for ensuring her patient has the medication she needs. Respondent could not discharge this responsibility by relying on a co-worker or her patient's family.

Because Respondent never directly notified her supervisors that Patient needed her own oxygen supplies—particularly by the second weekend she worked after Patient's ER visit, when Patient had been relying on her sister's oxygen for at least 10 days and it had been over a week since a fellow nurse said she had raised the matter with Viva Pediatrics—the evidence established that she failed to implement measures to promote a safe environment for her patient and failed to collaborate with the other members of Patient's medical team in the interest of Patient's health care, in violation of the minimum standards in Board Rule 217.11(1)(B) and (1)(P). This also evinced a failure to conform to the Board's rules, in violation of the minimum standard in Board Rule 217.11(1)(A).[32] This could have endangered the life or health of Patient or her sister, particularly given Respondent's expressed concern that there might not be enough supplemental oxygen on hand for both patients. Therefore, the Respondent's conduct also constituted unprofessional conduct as defined by Board Rule 217.12(1)(A)-(B) and 217.12(4).

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[31] Resp. Ex. 7.

[32] Staff also alleged that this conduct constituted a "failure to institute appropriate nursing interventions that might be required to stabilize a client's condition . . ." in violation of the minimum standard in Board Rule 217.11(1)(M). There was no testimony that calling her supervisor about a medication would constitute a "nursing intervention," and the evidence shows that when Patient needed supplemental oxygen, Respondent was able to promptly administer it. The ALJ does not find a violation of Rule 217.11(1)(M).

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

B. Charge II: Failure to Assess or Document Gastric Residual Volumes

For Charge II, Staff alleges that Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to assess her patient's gastric residual volumes prior to administering enteral feeds through the patient's gastronomy button on or about February 18, 2017, and/or by failing to document her assessments.

Respondent was credible in her testimony that she checked Patient's gastric residual volumes before every feeding and vented Patient to remove any excess gas from her stomach and tube. Respondent explained the reasons for these checks and understood the risk of aspiration if gastric volumes were not checked prior to a feeding. The preponderance of the evidence established that, contrary to Staff's allegations, Respondent did properly assess Patient's gastric residual volumes prior to administering feedings. Therefore, the allegation that Respondent violated Board Rule 217.11(1)(B) and (M) is not supported by the evidence.

However, the evidence is undisputed that Respondent never documented these checks. Her failure to accurately document required matters violated the minimum standard in Board Rule 217.11(1)(D), which also constituted a failure to conform to the Board's rules, in violation of the minimum standard in Board Rule 217.11(1)(A). Without adequate documentation, Patient's other caregivers would not know if Respondent had problems with her feedings or if there was a pattern emerging of poor gastric motility. Thus, her failure to conform to minimum nursing standards could have endangered Patient's health and also constituted unprofessional conduct as defined by Board Rule 217.12(1)(A)-(B) and 217.12(4).

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

C. Charge III: Failure to Report Change in Patient's Respiratory Status

For Charge III, Staff alleges that Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to report to her RN supervisor or Patient's primary care physician when Patient's respiratory status fluctuated and declined on or about February 18, 2017.

Based on Ms. Laws's testimony, Staff contends there were at least four occasions on February 17-18, 2017, when Respondent should have recognized a need to notify other caregivers that Patient's status had declined. For example, Staff contends that Respondent should have called when, on Friday, February 17, 2017, she observed congestion and had to administer a nebulizer treatment at the start of her shift. The ALJ does not agree that this represented a change in Patient's condition that should have caused immediate concern. Rather, the medical records show that Patient's plan of care—prepared in January, prior to her upper respiratory infection—anticipated that Patient's nurses would need to administer prn breathing treatments and regularly suction her secretions.[33] Respondent had then been caring for Patient for over a year, and she testified that wheezing and congestion were not uncommon. Moreover, her notes state that Patient was reassessed at 6:30 a.m., only half an hour after the shift started, and her "congestion seem[ed] good."[34] The preponderance of the evidence does not show that Patient's condition at the start of her shift necessitated a call to other members of the medical team.

However, later Friday morning, Respondent had to administer supplemental oxygen after Patient's oxygen saturation dropped to 87%. To raise her saturation level back above 90%, Respondent had to administer oxygen at a rate of 2L/min, the maximum rate authorized by the ER physician's order. This prompted Respondent to call Patient's parents and advise them that Patient was too ill to attend school that day. The ALJ agrees with Staff that Respondent should also have called her RN supervisor at that point to give notification of Patient's change in condition. Though Patient had been battling the upper respiratory infection for over a week at that point, her medical

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[33] Staff Ex. 6 at 14, 16.

[34] Staff Ex. 6 at 6.

records indicate that she had not needed supplemental oxygen for at least the previous five days.[35] Patient's fluctuating oxygen saturation levels that morning, and the sudden need to administer supplemental oxygen to maintain a safe saturation level, should have prompted Respondent to reach out to other members of Patient's medical team to discuss the implications of these changes and formulate a plan for how to proceed if she continued to worsen.

The following morning, Respondent arrived for her shift and learned that Patient had needed supplemental oxygen since approximately midnight, and she recorded that Patient's oxygen saturation was only 90% with 1L/min of oxygen flowing. This represented a decline over Patient's baseline (pre-infection) oxygen level, as well as her status the morning before. The ALJ agrees with Staff that this was another circumstance when Respondent should have recognized that her patient had declined and reported that to her RN supervisor or Patient's physician.[36]

Finally, Staff contends that Respondent should have called her RN supervisor later that Saturday morning, when the nursing notes indicate Patient's oxygen saturation dropped to 85% at 10:30 a.m. Ms. Laws believes that Respondent had approximately 40 minutes between that 10:30 a.m. reading and 11:10 a.m., when the notes state that Patient desaturated and could not be revived, even after Respondent increased the rate of supplemental oxygen to 2L/min. According to Ms. Laws, it was negligent to proceed with a feeding during that interval, and Respondent should have called other members of the medical team for help. Respondent has acknowledged inconsistencies in the time notations made in her notes that morning, but based on Respondent's testimony, it appears that 10:30 a.m. was the beginning of a sequence of events that started with Respondent administering the first half of a feeding. Respondent testified that the initial feeding was uneventful and it was during the 30-minute waiting period afterward that Patient began to suddenly desaturate. At that point, it was too late to call a supervisor or Patient's physician.

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[35] Staff Ex. 6 at 13.

[36] The evidence does not support Staff's contention that Patient's heart rate on Saturday, February 18, 2017, was another cause for alarm. On Thursday, Respondent had noted a pulse of 109 and 111 at the start and end of her shift. At the beginning of her shift on Saturday, Respondent recorded a pulse of 121. Ms. Laws testified that Respondent should have been concerned by the difference. However, in Patient's plan of care, her physician listed vital-sign parameters including "Respirations: 16 to 30" and "Pulse: 70 to 130." Staff Ex. 6 at 14. Patient's vital signs were within these parameters when Respondent recorded them Saturday morning.

Respondent recognized—and Ms. Laws agreed—that this was an emergency requiring a call to 911. The evidence does not show that there was an opportunity to call other health-care providers after Patient desaturated, and the call to 911 at that juncture was the appropriate response to Patient's sudden decline.

Still, as discussed above, Staff has shown that Respondent had the time and opportunity to call her supervisor or Patient's physician on February 17, 2017, when she needed to use supplemental oxygen for the first time to stabilize Patient's saturation level and determined her patient was too ill to attend school; and again on February 18, 2017, when she arrived for her shift and saw that Patient's respiratory status had declined from the day before. Respondent's failure to address and report these changes in her patient's condition constituted a violation of the minimum standards in Board Rule 217.11(1)(B), (G), and (M). Additionally, her failure to accurately document the events on February 18, 2017, violated the minimum standard in Board Rule 217.11(1)(D). These violations also constituted a failure to conform to the Board's rules, in violation of the minimum standard in Board Rule 217.11(1)(A).

Respondent's failure to conform to minimum nursing standards could have endangered Patient's health by depriving her of necessary medical interventions and thus also constituted unprofessional conduct as defined by Board Rule 217.12(1)(A)-(B) and 217.12(4).

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

D. Sanction Analysis

The Disciplinary Matrix categorizes violations into three tiers, in ascending order of seriousness. Whether sanctioning for unprofessional conduct pursuant to Code § 301.452(b)(10) or for failure to conform to minimum nursing standards pursuant to Code § 301.452(b)(13), Tier One applies only to violations where there was a low risk of patient harm or no risk to patient safety. Respondent's violations do not satisfy that condition. As discussed above, Respondent's

violations put Patient at risk of harm because Patient might not have had oxygen when needed; Patient's caregivers could have had incomplete information due to Respondent's documentation errors; and Patient could have needed interventions that were not recommended because Respondent failed to consult with other members of her medical team.

At the hearing, Ms. Laws testified that, in her opinion, Respondent's violations fall within Tier Three under both Code § 301.452(b)(10) and (13). That is the tier applicable to violations that result in "serious patient harm," and Ms. Laws believes Respondent may have caused Patient's death. Notwithstanding Ms. Laws's opinion, the ALJ notes that Staff's Formal Charges alleged only that Respondent's violations were "likely to injure the patient," but did not allege *actual harm*.[37] The preponderance of the evidence also did not establish that Respondent caused or directly contributed to Patient's death. Therefore, the ALJ does not agree with Ms. Laws's assessment that sanctions should be imposed under Tier Three.

That leaves Tier Two, the sanction level that Staff generally argues should apply to Respondent's violations.[38] Pursuant to Code § 301.452(b)(10), Tier Two applies when a nurse's violations result in a serious risk to a patient, while pursuant to Code § 301.452(b)(13), Tier Two applies to violations that result in patient harm or risk of patient harm. Here, though actual harm was not established, the ALJ agrees that Patient was placed at risk of harm by Respondent's violations and that the Tier Two is appropriate designation for these violations.

Within the second tiers for both failure to conform to minimum standards and unprofessional conduct, the Board must select Sanction Level I or II. If multiple violations are present, the Disciplinary Matrix directs that the most severe sanction recommended for any of the violations should be considered,[39] which supports imposition of a Level II sanction here. In

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[37] *See* Staff Ex. 4C.

[38] Alternatively, Staff suggested Respondent could be sanctioned under Tier Three, Sanction Level I pursuant to Code § 301.452(b)(13). *See* Staff's Closing Argument at 8.

[39] 22 Tex. Admin. Code § 213.33(c).

Sanction Level II, the Board can suspend or revoke the nurse's license, based upon the aggravating and mitigating factors in the Disciplinary Matrix and those listed in Board Rule 213.33(c).[40]

As aggravating factors warranting a higher sanction, Staff pointed to the fact that there were multiple violations and to the extreme vulnerability of Patient, a nonverbal pediatric patient. The ALJ agrees these aggravating factors apply.

Other aggravating factors asserted by Staff or Ms. Laws are not supported by the evidence. Ms. Laws blamed Respondent for Patient's death, claiming that if Respondent had called her RN supervisor during her shifts or if Respondent had not administered a feeding to Patient on February 18, 2017, the child might not have died. Ms. Laws's speculation on the cause of Patient's death is not supported by a preponderance of the evidence. Ms. Laws also testified that the Board "discourages" new nurses from working in positions where a supervisor is not present and should consider it an aggravating factor that Respondent was working in a home-health setting at all. However, Staff did not allege or cite to any regulation that prohibits licensed LVNs from working in home health. Staff also did not allege a violation of Board Rule 217.11(1)(T), the nursing standard that requires nurses to "[a]ccept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, [and] knowledge." The evidence does not support Ms. Laws's opinion that Respondent was unqualified or deserves a more serious sanction for holding a home-health position with Viva Pediatrics.

As for mitigating factors that might warrant a lower sanction, Ms. Laws initially testified that, in her view of the evidence, none were present. On cross-examination, Ms. Laws conceded that Respondent's continuing education towards her RN degree constituted remedial effort the Board could consider. Respondent's closing brief emphasized her education since 2017, citing the competency she demonstrated by completing school and obtaining a Florida RN license. Staff also does not dispute that Respondent has been working since Patient's death without any other known violations.

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[40] 22 Tex. Admin. Code § 213.33(b)-(c).

Taking these aggravating and mitigating factors into consideration, the ALJ finds that Respondent's violations best fit under Tier Two, Sanction Level II, whether the sanction is assessed pursuant to Code § 301.452(b)(10) or (13).

As a sanction, Ms. Laws did not recommend revoking Respondent's license. Rather, she testified that a two-year probated suspension would remediate Respondent's practice. As conditions of her probation, Ms. Laws testified that Respondent should be required to:

- complete courses in nursing jurisprudence and ethics, documentation, critical thinking, and professional accountability;
- notify her employers that she is working under a Board order, submit notice of her employment to the Board, and submit quarterly work evaluation forms to the Board;
- work under direct supervision for a full year, meaning her supervisor is present on the unit when Respondent is working; and
- then work under indirect supervision for a second year, with a supervisor on the premises but not necessary on the same unit.

Ms. Laws testified that these conditions and stipulations would address the Board's concerns about Respondent's training and experience but would allow her to continue working while under probation. Ms. Laws acknowledged that the supervision component would conflict with Respondent's current employment because it would exclude her from working in independent practice settings such as home health. The ALJ agrees that these requirements and stipulations are reasonably targeted to address the violations and ensure that Respondent is safe to practice independently again.

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

V. FINDINGS OF FACT

1. Christiana A. Akanbi, LVN (Respondent) holds Licensed Vocational Nurse (LVN) license No. 326454, issued by the Texas Board of Nursing (Board) in June 2015.

2. Respondent has worked for home-health agencies since receiving her license.

3. Beginning in or about 2016, while working for Viva Pediatrics, Respondent was assigned to provide in-home care for Patient, a pediatric patient with leukodystrophy and white matter disease. She typically worked 12-hour shifts beginning at 6:00 a.m. on weekends and other days as needed (prn).

4. Patient was not able to feed herself, move, or speak, and she also had a seizure disorder, among other diagnoses. Patient's sibling had the same conditions and also had an in-home registered nurse (RN) caring for her.

Charge I

5. On February 6, 2017, a day Respondent was not working, Patient was taken to the emergency room (ER) and treated for a viral upper respiratory infection. The ER physician's discharge orders directed that Patient should be given supplemental oxygen if her oxygen saturation levels declined and specified that she could use her sibling's oxygen until Patient had her own supply.

6. On Friday, February 10, 2017, Respondent arrived for her shift and learned of the emergency room visit. She reviewed Patient's medical record and then called the weekday nurse and Patient's mother for more information.

7. The nurse and Patient's mother told Respondent that Patient was still using her sister's oxygen supplies because they had not yet received Patient's own supply. The weekday nurse said Viva Pediatrics was aware of the order for Patient's oxygen supplies.

8. Respondent did not call her supervisors to report that oxygen was needed that day or during her shift the following day.

9. When Respondent worked her shifts the following weekend (February 16-18, 2017), Patient was still using her sister's oxygen supply as needed, and Respondent did not report this to her supervisors at Viva Pediatrics.

10. On Friday, February 17, 2017, Respondent expressed concern to Patient's mother about the need to obtain supplemental oxygen for Patient, and the mother immediately called the equipment company to inquire about Patient's order.

11. As the nurse, it was ultimately Respondent's responsibility to make sure her patient had the medication she needed. Respondent could not discharge this responsibility by relying on a co-worker or her patient's family.

12. Relying on the sister's oxygen supply placed both Patient and her sister at risk of harm in the event there was not enough supplemental oxygen for both patients.

Charge II

13. Patient's feedings were administered enterally through a gastronomy button. Her gastric residual volumes had to be assessed prior to every feeding to ensure that she had digested the previous feeding.

14. If Patient's stomach was still full of fluid or gas when a feeding started, she could aspirate the fluid into her lungs.

15. As part of her routine care for Patient since 2016, Respondent checked Patient's gastric residual volumes before every feeding and vented her to remove any excess gas from the stomach and tube. Respondent understood the risks to Patient if these checks were not performed.

16. It was important to document checks of gastric residual volumes so Patient's other caregivers could note any problems with her feedings or detect an emerging pattern of poor gastric motility.

17. In 2017, it was not Respondent's practice to document checks of gastric residual volumes.

18. Respondent did not document Patient's gastric residual volumes in her nursing notes on or about February 18, 2017.

Charge III

19. Respondent worked a prn shift with Patient on Thursday, February 16, 2017, and did not need to use supplemental oxygen during that shift. Patient had also not required supplemental oxygen during the four previous days, February 12-15, 2017.

20. When Respondent began her shift at 6:00 a.m. on Friday, February 17, 2017, Patient's oxygen saturation rate was 92% on room air, meaning the patient was not using supplemental oxygen at that time.

21. Wheezing and congestion were not uncommon for Patient, even prior to her February infection. Patient's plan of care, prepared prior to her respiratory infection, directed the nurse to suction and administer breathing treatments as needed.

22. Patient's lungs seemed congested at the start of Respondent's shift on February 17, 2017, but after receiving medication and being repositioned, Patient was reassessed at 6:30 a.m. and Respondent wrote that her "congestion seem[ed] good."

23. At approximately 9:30 a.m. on February 17, 2017, Patient's oxygen saturation dropped to 87%, and Respondent had to administer two liters/minute (2L/min) of oxygen—the maximum rate authorized by the ER physician's order—to raise the level back above 90%. Her oxygen level then continued to fluctuate that day, but stayed above 90%.

24. Respondent called Patient's parents and advised them that she did not think Patient was well enough to go to school on February 17, 2017. She did not call her RN supervisor or Patient's physician to report Patient's condition had worsened.

25. Patient's fluctuating oxygen saturation levels that morning, and the sudden need to administer supplemental oxygen to maintain a safe saturation level, should have prompted Respondent to reach out to other members of Patient's medical team to discuss the implications of these changes and formulate a plan for how to proceed if Patient's condition continued to worsen.

26. Respondent's failure to report Patient's change in condition could have endangered Patient's health by depriving her necessary medical interventions.

27. The following morning, February 18, 2017, Respondent arrived for her shift and learned that Patient had needed supplemental oxygen since approximately midnight, and she recorded that Patient's oxygen saturation was only 90% with 1L/min of oxygen flowing. This represented a decline over Patient's baseline (pre-infection) oxygen level, as well as her status the morning before.

28. Respondent should have recognized at the start of her shift on February 18, 2017, that her patient had declined since the previous day and discussed the implications of these changes with her RN supervisor or Patient's physician.

29. Respondent's failure to report Patient's declining condition could have endangered Patient's health by depriving her of necessary medical interventions.

30. After Respondent suctioned Patient, administered a feeding and a breathing treatment, and performed oral care, Patient's oxygen saturation increased to 96%, but it continued to fluctuate all morning.

31. After giving Patient the first part of a feeding at approximately 10:30 a.m., Respondent was in the kitchen preparing the second part of the feeding when Patient's pulse oximeter began to alarm at approximately 11:10 a.m.

32. In responding to the alarm, Respondent saw that Patient's oxygen saturation had decreased to 88% and she increased the rate of supplemental oxygen to 2L/min. However, Patient continued to desaturate and her oxygen saturation level fell to 78%, even with the supplemental oxygen.

33. Respondent immediately recognized that the situation was an emergency and called 911. There was no time to call Patient's physician or her RN supervisor prior to calling 911.

34. During the emergency, Respondent was assisted by Patient's sister's nurse, who helped her administer CPR until paramedics arrived.

35. Patient was transported by ambulance to Cook Children's Medical Center, but she could not be revived and was pronounced dead later that day.

36. After returning from the hospital, Respondent completed her nursing notes for her February 18, 2017 shift. Some of the time notations in Respondent's notes were inaccurate.

Sanctions Factors

37. Though actual harm was not established, Patient was placed at risk of harm by Respondent's violations.

38. Patient was an extremely vulnerable patient.

39. Respondent committed multiple violations of the Board's rules in caring for Patient.

40. Respondent has no other disciplinary history with the Board.

41. Respondent has been working in home health since Patient's death without any other known violations.

42. Respondent has worked for Vigor Care Pediatric Services since October 2017, and her nursing director wrote a letter stating that Respondent provides good care and turns in timely and proper documentation.

43. Respondent returned to school at the Essential School of Nursing in Miami, Florida, and obtained an RN degree in 2020.

44. Respondent now holds an RN license in Florida.

45. In April 2020, Respondent completed a two-hour Texas Nursing Jurisprudence and Ethics course.

46. In July 2017, Respondent completed a two-hour course on making accurate and legal documentation.

Procedural Background

47. In June 2017, the Board initiated an investigation of Respondent after receiving a report concerning care she provided for Patient.

48. Formal Charges were filed in March 2018.

49. On February 5, 2020, Board staff (Staff) docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas.

50. On March 17, 2021, Staff sent Respondent a Third 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.

51. On April 21, 2021, SOAH ALJ Sarah Starnes convened the hearing via Zoom videoconference. Assistant General Counsel John Vanderford represented Staff, and attorney Lurese A. Terrell represented Respondent. The record closed on May 24, 2021, after the parties filed their written closing arguments.

VI. CONCLUSIONS OF LAW

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

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

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

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

5. By failing to directly notify her supervisors that her patient needed oxygen supplies, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A), (B), and (P), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code § 217.12(1)(A)-(B) and (4).

6. By failing to document the gastric residual volumes assessed prior to her patient's feedings, and by failing to accurately document events in her February 18, 2017 nursing notes, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A) and (D), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code § 217.12(1)(A)-(B) and (4).

7. By failing to report Patient's respiratory decline on February 17 and 18, 2017, to Patient's medical team, Respondent violated the minimum nursing standards in 22 Texas Administrative Code § 217.11(1)(A)-(B), (G), and (M), and engaged in unprofessional conduct as defined by 22 Texas Administrative Code § 217.12(1)(A)-(B) and (4).

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

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

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

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

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

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board impose a probated suspension on Respondent's RN license for two years. Her probated suspension should require direct supervision for one year and indirect supervision for the second year, as well as appropriate educational requirements and other stipulations.

SIGNED July 19, 2021.

Sarah Starnes

SARAH STARNES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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507-20-2433
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Carol Hale, CLERK

SOAH DOCKET NO. 507-20-2433

TEXAS BOARD OF NURSING **Petitioner,**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
CHRISTIANA AKANBI, LVN **Respondent.**	§	**ADMINISTRATIVE HEARINGS**

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

COMES NOW, Respondent Christiana Akanbi, and files these exceptions to the SOAH Proposal for Decision, and would show the Court the following:

SOAH Weighted the Board's Supposition Too Heavily in Light of the Facts Presented

1. The Board's witness attributed the heart attack and death of the patient to Ms. Akanbi's actions and inactions. There is no evidence that Ms. Akanbi's actions or inactions had anything to do with the patient's death. The Board's witness stated that Board attributed the death of the patient to Ms. Akanbi, and the Board doesn't like the fact that newly licensed nurses practice in home health. The Board had no evidence to support its supposition that the death was attributable to the nurse, and the Board does not limit a newly licensed nurse's practice area. The Board, and subsequently the ALJ, weighted too heavily the fact that the patient died while in Ms. Akanbi's care. The length of time under supervision, two years, is not supported by facts in the record, but only supported by the Board's witness's supposition.

Akanbi Followed the Physician's Orders

2. In the discharge of her duties, Ms. Akanbi followed the physicians' orders for the home health treatment of the patient, a child with leukodystrophy, and for the recent viral infection. Akanbi was under two physician's orders, and both were followed by Akanbi.

3. Because the patient's infection was viral, and would not respond to antibiotics, the ER physician made no change in the home health orders, other than to instruct the nurse to administer oxygen if the patient's oxygen saturation (O2 sat) dropped below 90%. *See* Respondent's Exhibit 7. None of the other home health parameters were changed. (Vital sign parameters are found at Staff's Exhibit 6, page 14). The O2 sat is not specified by the home health physician, so the nurse relied on the ER physicians' order. (Respondent's Exhibit 7).

4. Ms. Akanbi followed the physician's order for oxygen. When the patient's O2 sat dropped below 90%, put the patient on supplemental oxygen, and the patient's O2 sat quickly returned to what it had been previously, which was within the home health physicians' parameters.

5. Ms. Akanbi was limited to the home health and ER physicians' orders for the routine care of the patient. However, the Board holds the nurse to a higher standard than the doctor's orders, and, in hindsight, the Board required the nurse to act when there was no sign or symptom that was outside the doctor's orders, or that would have given the nurse any indication to act any differently than she acted.

6. Ms. Akanbi had been the weekend nurse for this patient for well over a year. Ms. Akanbi had followed the home health physician's orders for that time period. The patient's stats and vitals were not outside the home health parameters at any time, except just before the instance that immediately preceded the patient's death. *See* Staff's Exhibit 6, pages 2-17 (date reverse order

and the physician order is on pages 14-17). The patient had no signs of respiratory distress on the dates in question. The patient had the normal secretions and the typical breathing treatments were given, and the patient was cleared as needed. Nothing that presented to Ms. Akanbi was outside the doctor's home health parameters until the instance that immediately preceded the patient's death.

Conclusion

The two-year supervisory sanction is excessive in light of the fact that there is nothing to support that length of time other than the Board's witness's statements that indicate that she holds the nurse responsible for the death of the patient, notwithstanding physicians' orders. None of the medical records in evidence relate the actions or inactions of the nurse to the death. The two-year supervisory sanction is excessive and unwarranted.

Respectfully submitted,

KENNEDY
Attorneys and Counselors at Law

/s/ Lurese A. Terrell
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ATTORNEYS FOR RESPONDENT

CERTIFICATE OF SERVICE

On July 29, 2021, a true and correct copy of the forgoing document was served on Mr. John Vanderford, counsel for Respondent Texas Board of Nursing through the eFile Texas electronic filing system.

/s/ Lurese A. Terrell
LURESE A. TERRELL

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State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

August 20, 2021

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

VIA EFILE TEXAS

RE: Docket No. 507-20-2433; Texas Board of Nursing v. Christiana A. Akanbi

Dear Ms. Thomas:

On July 19, 2021, the undersigned Administrative Law Judge (ALJ) issued a Proposal for Decision (PFD) in this case. Respondent Christiana A. Akanbi filed timely exceptions on July 29, 2021. Staff of the Texas Board of Nursing did not file exceptions, nor did Staff respond to Respondent's exceptions.

In her exceptions, Respondent argues that the ALJ gave too much weight to the opinions of Staff witness Linda Laws, who testified that she attributed the patient's death to Respondent and that she believed Respondent was too inexperienced to work in home health. In fact, the ALJ gave little weight to these opinions. The PFD expressly states the evidence "did not establish that Respondent caused or directly contributed to Patient's death" and "does not support Ms. Laws's opinion that Respondent was unqualified or deserves a more sanction for holding a home-health position . . . ."[1]

Respondent also generally argues that the evidence does not support the sanction recommended by the PFD. Her arguments, and the basis for the ALJ's sanction recommendation, have already been addressed at length in the PFD.[2]

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[1] Proposal for Decision at 20, 21.
[2] Proposal for Decision at 19-22.

For these reasons, the ALJ does not recommend amending the PFD in response to Respondent's exceptions, and the PFD is ready for your review.

Sincerely,

Sarah Starnes

Sarah Starnes
Administrative Law Judge

SS/tt

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA EFILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA EFILE TEXAS**
Lurese Terrell, Kennedy Attorneys and Counselors at Law, 12222 Merit Drive, Suite 1750, Dallas, TX 75251 - **VIA EFILE TEXAS**