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Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of § AGREED ORDER
Registered Nurse License Number 743899 §
& Vocational Nurse License Number 204346 §
issued to KINYA D. MITCHELL §
§

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of KINYA D. MITCHELL, Registered Nurse License Number 743899, and Vocational Nurse License Number 204346, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13)(effective through 8/31/2021), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on October 14, 2021.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.
3. Respondent's license to practice as a vocational nurse in the State of Texas is in delinquent status. Respondent's license to practice as a professional nurse in the State of Texas is in current status.
4. Respondent received a Certificate in Vocational Nursing from Paris Junior College, Paris, Texas, on May 12, 2006. Respondent received an Associate Degree in Nursing from Paris Junior College, Paris, Texas, on May 30, 2007. Respondent was licensed to practice vocational nursing in the State of Texas on June 13, 2006. Respondent was licensed to practice professional nursing in the State of Texas on July 3, 2007.

5. Respondent's nursing employment history includes:

06/2006 – 06/2007	Unknown	
07/2006 – 07/2008	Registered Nurse	Paris Regional Medical Center Paris, Texas
08/2008 – 10/2011	Registered Nurse	Signature Nurses Phillipsburg, Kansas
11/2011 – 03/2012	Assistant Director of Nurses	Founders Plaza Nursing and Rehabilitation Wylie, Texas
03/2012 – 02/2015	Registered Nurse	Parkland Memorial Hospital Dallas, Texas
02/2015 – 07/2017	Registered Nurse	Texoma Medical Center Bonham, Texas
07/2017 – 06/2018	Registered Nurse	Texas Health Presbyterian Hospital Denton, Texas
06/2018 – 04/2020	Registered Nurse	CHRISTUS Mother Frances Hospital Sulphur Springs, Texas
07/2018 – 12/2019	Director of Nursing	First Surgery Suites Sulphur Springs, Texas
05/2020 – Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with CHRISTUS Mother Frances Hospital, Sulphur Springs, Texas, and had been in that position for one (1) year and eight (8) months.

7. On or about February 27, 2020, while employed as a Registered Nurse with CHRISTUS Mother Frances Hospital, Sulphur Springs, Texas, Respondent withdrew a 25mg capsule of chlorthalidone (Librium) from the medication dispensing system for Patient Number 400064744378, in excess of the physician's order, and documented administration of a 10mg capsule in the patient's medication administration record, even though the pharmacy was unable to supply a 10 mg capsule and the Respondent cut the pill herself as best she could. Respondent's conduct resulted in an inaccurate medical record, and exposed the

patient to a risk of harm in that the administration of medication in excess dosage of the physician's order could result in the patient suffering from adverse reactions.

8. On or about March 19, 2020, while employed as a Registered Nurse with CHRISTUS Mother Frances Hospital, Sulphur Springs, Texas, Respondent inaccurately documented in the patients' Medication Administration Record (MAR) that she administered lorazepam (Ativan) to Patient Number 400065295890 and pregabalin (Lyrica) to Patient Number 400065192851, in that the medication dispensing system did not reflect an associated pull prior to the time of either administration. Respondent's conduct created inaccurate medical records and failure to administer medication as ordered by the physician could have resulted in non-efficacious treatment.
9. On or about March 22, 2020, while employed as a Registered Nurse with CHRISTUS Mother Frances Hospital, Sulphur Springs, Texas, Respondent incorrectly increased a heparin drip from 8 units/kg/hr to 18 units/kg/hr, instead of 10 units/kg/hr per protocol when the PTT result came back as 30 on an Intensive Care Unit (ICU) patient. Respondent's conduct was likely to injure the patient in that failing to administer heparin per protocol could result in the patient suffering from adverse reactions.
10. In response to the incident in Findings of Fact Number Seven through Nine, Respondent states that the above incidents occurred during the beginning of the COVID-19 pandemic. The pharmacy did not have any more 10mg or 5mg chlorthalidone (Librium) capsules. Therefore, Respondent was advised by the pharmacy to cut the capsule as best she could. In response to the incident in Finding of Fact Number Eight, Respondent states that she did pull and administer the medication for both patients and the administrations were documented in the patients' medical records. The inaccuracy in her documentation came from the time in which she documented the medications were administered. Respondent stated that the pharmacy would tell ICU nurses to adjust the time of administration in order to avoid the pharmacy having to go back and readjust all the medication times. Respondent therefore adjusted her documentation in order to avoid the pharmacy having to take such action. When she adjusted her administration times it created a medical record for each patient that looked like she had administered the medication prior to pulling the medication. When in fact, she had not, she had just readjusted the time of administration. The difference in time was less than 15 minutes. In response to the incident in Finding of Fact Number Nine, Respondent was working with an LVN that she believed to be an RN. By law the hospital was not supposed to send an LVN to the ICU. She understands that she still should have verified the LVN's actions before the increase and she should have caught her mistake. Had Respondent known that she was an LVN, she would have watched her more carefully and probably caught her mistake before it happened.
11. On or about August 23, 2020, Respondent successfully completed a course in Texas Nursing Jurisprudence and ethics, which would have been a requirement of this order.
12. Formal Charges were filed on June 14, 2021.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B),(1)(C),(1)(D)&(1)(M) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(4),(10)(B)&(11)(B).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13) (effective through 8/31/2021), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 743899, and Vocational Nurse License Number 204346, heretofore issued to KINYA D. MITCHELL.
5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

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

- A. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.
- B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.
- C. 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.

II. COMPLIANCE WITH LAW

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

III. UNDERSTANDING BOARD ORDERS

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

IV. REMEDIAL EDUCATION COURSE(S)

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

- A. **A Board-approved course in medication administration** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the

course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

- 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.*

V. **EMPLOYMENT REQUIREMENTS**

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for 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:** 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.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

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

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RESPONDENT'S CERTIFICATION

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

10/21/2021

Signed this 21 day of October 2021.
Kinya Mitchell
KINYA D. MITCHELL, RESPONDENT

Approved as to form and substance.

Kerry Bloodsaw
Kerry Bloodsaw, Attorney for Respondent

Signed this 21 day of October 2021.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 21st day of October, 2021, by KINYA D. MITCHELL, Registered Nurse License Number 743899, and Vocational Nurse License Number 204346, and said Agreed Order is final.

Effective this 9th day of November, 2021.



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