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*Patricia A. Thomas*  
Executive Director of the Board

**DOCKET NUMBER 507-21-2275**

**IN THE MATTER OF § BEFORE THE STATE OFFICE**  
**PERMANENT CERTIFICATE § OF**  
**NUMBER 69316, §**  
**ISSUED TO**  
**SHARON R. BROTHERS § ADMINISTRATIVE HEARING!**

**OPINION AND ORDER OF THE BOARD**

TO: SHARON R. BROTHERS  
C/O ELIZABETH HIGGINBOTHAM,  
ATTORNEY  
HIGGINBOTHAM & ASSOCIATES, LLC  
ONE CASTLE HILLS  
1100 NW LOOP 410, STE 700  
SAN ANTONIO, TX 78213

AMY DAVIS  
ADMINISTRATIVE LAW JUDGE  
300 WEST 15TH STREET  
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 20, 2022, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; 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. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; 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 violations of §301.452(b)(10) & (13)<sup>1</sup>. 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)<sup>2</sup>. The Board agrees with the ALJ that a two year probated suspension with stipulations is the most appropriate sanction in this matter<sup>3</sup>.

The Respondent's conduct placed a vulnerable patient at risk of harm<sup>4</sup>. Further, cardiopulmonary resuscitation (CPR) is a fundamental skill that any nurse should be ready to apply in the absence of a do-not-resuscitate (DNR) order<sup>5</sup>. The Respondent should have known to provide the life-saving intervention given the length of her licensure prior to this event<sup>6</sup>.

The ALJ found it mitigating that the Respondent had practiced for over forty years and has no prior disciplinary history<sup>7</sup>.

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e), that a 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 professional accountability course, and a course in CPR<sup>8</sup>. The Board

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<sup>1</sup> See adopted Conclusions of Law Numbers 5-6 and 9 of the PFD and pages 10-11 of the PFD.

<sup>2</sup> See §213.33(b).

<sup>3</sup> The ALJ alludes to probating the suspension of the Respondent's license *after* the educational requirements and stipulations are met. See page 11 of the PFD. However, this statement appears inconsistent with the general discussion and sanction analysis of the ALJ on pages 1, 7, other portions of 11, and 14 of the PFD. As such, the Board finds that, although authorized by the Disciplinary Matrix, an enforced suspension of the Respondent's license until such time as the stated stipulations are met would be overly punitive given the evidence in the case, and that a probated suspension, followed by probationary stipulations, is the most appropriate sanction in this matter.

<sup>4</sup> See pages 10-11 of the PFD.

<sup>5</sup> See *id.*

<sup>6</sup> See page 9 of the PFD.

<sup>7</sup> See pages 10-11 of the PFD.

<sup>8</sup> 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 Board notes that the ALJ lists a documentation course in her sanction discussion on page 11 of the PFD as it relates to the courses recommended by Dr. Benton; this differs from the courses listed on page 7 of the PFD as they relate to the courses recommended by Dr. Benton. Because the adopted Findings of Fact and Conclusions of Law do not support a course in documentation, the Board declines to require a documentation course, but finds that the completion of a professional accountability course is appropriate remediation and conforms to the evidence in the

also agrees with the ALJ that the Respondent's nursing practice should be supervised. Specifically, the Board finds that 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)<sup>9</sup>.

IT IS THEREFORE ORDERED that Vocational Nurse License Number 69316, previously issued to SHARON R. BROTHERS, 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

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case.

<sup>9</sup> 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.

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

### III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the 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. **The course "Professional Accountability ...,"** a 5.4 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.
- D. **Within sixty (60) days of entry of this Order,** a course in Basic Cardiopulmonary Life Support for Healthcare Providers that shall be, at a minimum, four and one half (4 ½) hours in length. The course's content shall include: Adult, Infant, and Child 1- and 2-Rescuer CPR; Adult, Infant, and Child Foreign Body Airway Obstruction for both responsive and unresponsive victims; and Adult Automated External Defibrillation. 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](http://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:** For the remainder of the Order, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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 20<sup>th</sup> day of January, 2022.

TEXAS BOARD OF NURSING

A handwritten signature in black ink, appearing to read "Katherine A. Thomas". The signature is written in a cursive style with a large initial 'K'.

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

Attachment: Proposal for Decision; 507-21-2275 (September 27, 2021)



# State Office of Administrative Hearings

Kristofer S. Monson  
Chief Administrative Law Judge

September 27, 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. 507-21-2275; Texas Board of Nursing v. Sharon  
R. Brothers**

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](http://www.soah.texas.gov).

AMY DAVIS  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS

AD/jh

xc: Jacqueline A. Strashun, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS**  
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS and INTERAGENCY MAIL**  
Elizabeth L. Higginbotham, Higginbotham & Associates, LLC, One Castle Hills, 1100 NW LOOP 410 Ste. 700, San Antonio, TX 78213 – **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-21-2275

TEXAS BOARD OF NURSING,  
Petitioner

v.

SHARON R. BROTHERS,  
Respondent

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

**PROPOSAL FOR DECISION**

The staff (Staff) of the Texas Board of Nursing (Board) seeks to take disciplinary action against the licensed vocational nurse (LVN) license held by Sharon R. Brothers because she allegedly failed to initiate emergency life-saving measures for an unresponsive patient (Patient). The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the allegation by a preponderance of the evidence and recommends that the Board issue a probated suspension of two years to include direct supervision for one year and indirect supervision for the second year, as well as appropriate educational requirements and other stipulations.

**I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY**

Notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion. The hearing convened July 27, 2021, before ALJ Meaghan Bailey via Zoom videoconferencing. Staff was represented by Jacqueline Strashun, Assistant General Counsel. Ms. Brothers appeared through her attorney, Elizabeth Higginbotham. The record closed at the conclusion of the hearing the same day. The case was reassigned to ALJ Amy Davis, who listened to the audio recording of the hearing, reviewed the evidence, and prepared this Proposal for Decision.<sup>1</sup>

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<sup>1</sup> See 1 Tex. Admin. Code § 155.151.

## II. APPLICABLE LAW AND STAFF'S CHARGES

The Texas Nursing Practice Act, found in chapter 301 of title 3, subtitle E of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, failure to meet minimum standards of nursing practice (pursuant to Code § 301.452(b)(13))<sup>2</sup> or unprofessional conduct (under Code § 301.452(b)(10)). Staff asserts that Ms. Brothers's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to Board Rules 217.11 and 217.12.<sup>3</sup>

Board Rule 217.11 addresses minimum standards of nursing practice, and Staff alleged Ms. Brothers is subject to sanction under four provisions:

- **Board Rule 217.11(1)(A):** Failure to know and conform to the Code and Board rules as well as all federal, state, or local laws, rules, or regulations affecting the nurse's current area of practice;
- **Board Rule 217.11(1)(B):** Failure to implement measures to promote a safe environment for clients and others;
- **Board Rule 217.11(1)(C):** Failure to know the rationale for and the effects of medications and treatments and correctly administer the same; and
- **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.

Staff also alleges three violations of Board Rule 217.12, which addresses unprofessional conduct.<sup>4</sup>

- **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 Rule 217.11.

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<sup>2</sup> Effective September 1, 2021, Code § 301.452(b)(13) has been renumbered as § 301.452(b)(14). This Proposal for Decision (PFD) cites the version of the statute in effect in September 2017, when the conduct at issue occurred.

<sup>3</sup> 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 \_\_\_\_."

<sup>4</sup> Board Rule 217.12(1)(A), (B) and (4) were revised effective February 25, 2018 and again October 17, 2019. The amendments removed the words "carelessly or repeatedly" before "failing" in Board Rule 217.12(1)(B) and the words "careless or repetitive" before "conduct" in Board Rule 217.12(4). Also deleted from Board Rule 217.12(4) was the sentence, "Actual injury to a client need not be established." Staff's allegations relate to one incident occurring on September 8, 2017; therefore, this PFD cites the former versions of Board Rule 217.12(1)(A), (B), and (4).

- **Board Rule 217.12(1)(B):** Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings; and
- **Board Rule 217.12(4):** Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

When a nurse has violated the Code or Board rules, the Board is required to impose a disciplinary sanction.<sup>5</sup> Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.<sup>6</sup> 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 patient 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. Staff had the burden of proving its allegations by a preponderance of the evidence, and Ms. Brothers had the burden of establishing any mitigating factors.<sup>7</sup>

Staff presented one charge:

- **Charge I:** On or about September 8, 2017, Ms. Brothers failed to initiate cardiopulmonary resuscitation (CPR) and activate a code for an unresponsive patient.

### III. DISCUSSION

#### A. Evidence

Staff offered twelve exhibits that were admitted without objections.<sup>8</sup> Ms. Brothers did not offer documentary evidence. Staff called Ms. Brothers as a witness and offered Dr. Kristin Benton,

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<sup>5</sup> Code § 301.453; Board Rule 213.33(e).

<sup>6</sup> The Disciplinary Matrix was revised effective April 21, 2019, but the classification of tiers and sanctions of offenses under Code § 301.452(b)(10) and (13) was unaffected.

<sup>7</sup> 1 Tex. Admin. Code § 155.427.

<sup>8</sup> Staff Exs. 1-4, 5a-5c, and 7-12; Staff Exhibit 6, a copy of Ms. Brothers's employment file, was admitted subject to the limitation that only information about Ms. Brothers's conduct on September 8, 2017, be considered.

Director of Nursing for the Board, as a regulatory expert. As set out below, the key facts in this case are undisputed. Ms. Brothers conceded that she did not perform CPR on Patient despite finding Patient unresponsive. The parties disagree on whether Ms. Brothers had a duty to Patient and, if disciplinary action is warranted, the appropriate disciplinary action for Ms. Brothers's conduct.

## 1. Background

Ms. Brothers received her LVN license (license no. 69316) on November 19, 1976, and it was in delinquent status at the time of the hearing.<sup>9</sup> Her professional background includes employment as an LVN and as a private duty nurse in home health care for Baptist Medical Center, Medical Staffing Network (Hospice Care), Everlasting Home Health Care, and Adaptive Health Services.<sup>10</sup> In 2014, Ms. Brothers began working for Mesa Vista Inn Health Center (Mesa Vista) as a charge nurse.<sup>11</sup>

On September 8, 2017, Ms. Brothers was employed as an LVN with Mesa Vista working the 10:00 p.m. to 6:00 a.m. shift as the charge nurse for the 500 and 700 Halls of Mesa Vista, and Ms. Christina Fraser, another LVN, was working the same shift for the 600 and 800 Halls of Mesa Vista.<sup>12</sup> In addition to her charge nurse duties, Ms. Brothers also had her own patients assigned to her.

The 800 Hall of Mesa Vista included a 93-year-old, partially paralyzed patient (Patient). Patient had been admitted to Mesa Vista for hospice care on September 2, 2017, with a cerebral infarction (commonly known as a stroke) and spastic hemiplegia affecting her right side, among other diagnoses.<sup>13</sup> Patient was assigned to Ms. Fraser for the 10:00 p.m. to 6:00 a.m. shift on September 8, 2017.

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<sup>9</sup> Staff Ex. 1 at 1; Ms. Brothers is currently not working as a nurse but intends to return to the nursing profession.

<sup>10</sup> Staff Ex. 6 at 3, 9.

<sup>11</sup> Staff Ex. 6 at 13.

<sup>12</sup> Staff Ex. 7 at 1.

<sup>13</sup> Staff Ex. 9 at 15-16.

On September 8, 2017, at approximately 3:10 a.m., Ms. Fraser checked Patient and found her to be awake with eyes open and without any signs of respiratory distress. Ten minutes later, at 3:20 a.m., Ms. Fraser again checked Patient, and Patient was found unresponsive, with eyes closed, no respirations, and without a pulse. At some point, Ms. Brothers also assessed Patient. At 4:12 a.m., Patient was pronounced dead by Patient's hospice nurse.<sup>14</sup>

## 2. Testimony of Ms. Brothers

Ms. Brothers testified that she had no interactions with Patient before or after her assessment of Patient on September 8, 2017. Ms. Brothers did not know Patient's diagnoses or code status, including whether Patient had a do-not-resuscitate (DNR) order. Ms. Brothers testified that prior to her assessment of Patient, she had observed Ms. Fraser and Patient's hospice nurse talking throughout the night about Patient. She also observed Ms. Fraser and two certified nursing assistants (CNAs) talking together while standing outside of Patient's door and looking in at Patient. Ms. Brothers estimated that Ms. Fraser and the two CNAs were talking for approximately five to ten minutes before Ms. Fraser called to Ms. Brothers to "check on" Patient to see if Patient was responsive.

Ms. Brothers entered Patient's room and assessed Patient. Ms. Brothers observed that Patient was not breathing. She touched Patient's neck and could not detect a pulse. Ms. Brothers also observed that Patient's skin was warm to the touch and her mouth was open. After Ms. Brothers assessed Patient, she exited Patient's room. Ms. Fraser asked Ms. Brothers what needed to be done, and Ms. Brothers told Ms. Fraser to call Patient's doctor, the hospice care nurse, and Patient's family. Neither Ms. Fraser nor Ms. Brothers initiated CPR on Patient.

Ms. Brothers testified that she did not observe any sense of urgency, emergency, or distress from Ms. Fraser when Ms. Fraser asked her to assess Patient's responsiveness during the early morning hours of September 8, 2017. Ms. Brothers explained that Ms. Fraser's casual demeanor

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<sup>14</sup> Staff Ex. 9 at 9.

indicated to her that there was no need for a crash cart or other emergency intervention measures in regards to treating Patient since Ms. Fraser was Patient's assigned nurse. Ms. Brothers testified that Ms. Fraser did not ask her to take over Patient's care nor did Ms. Fraser provide her with any information regarding Patient. It appeared to Ms. Brothers that Ms. Fraser was seeking only her confirmation that Patient no longer had a pulse – not that Ms. Fraser needed her to intervene in Patient's care.

In her testimony, Ms. Brothers admitted that it was incorrect of her to assume that Patient had a DNR order without first confirming Patient's paperwork. She also acknowledged that she has been trained in CPR. However, she stressed that because Patient's assigned nurse, Ms. Fraser, was present, it was Ms. Fraser's responsibility to have known Patient's code status. Ms. Brothers explained that when Ms. Fraser then asked her what needed to be done, Ms. Brothers told her to call Patient's hospice nurse, doctor, and family.

Ms. Brothers also testified that at Mesa Vista a patient's code status was posted on the door of each patient's room and included in the patient's medical charts. Patients at Mesa Vista were not marked with their code status with a bracelet or other form of identification on their bodies. Ms. Brothers stated that she did not look at Patient's door to determine Patient's code status when she went to assess Patient at Ms. Fraser's request.

### **3. Testimony of Dr. Kristin Benton**

Dr. Benton<sup>15</sup> testified as an expert on the Board's governing statutes and rules, and on the minimum standards of nursing practice. She said that LVNs have a limited scope of practice and are unable to pronounce death. She explained that in the case of an unresponsive patient, a nurse should assess a patient and determine whether the patient has a pulse and is breathing. If not, the nurse should begin CPR. She testified that as soon as Ms. Brothers assessed Patient and found Patient to be unresponsive, Ms. Brothers had a duty to intervene in Patient's care. She noted that Ms. Brothers did not observe any conclusive signs of death (rigor mortis, decapitation, or decay)

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<sup>15</sup> Dr. Benton holds a doctoral degree in nursing and is not a physician. Staff Ex. 11.

and that Ms. Brothers's assumption that Patient was dead was unreasonable. She also explained that if an LVN finds an unresponsive patient, CPR should be initiated unless there is a known DNR order.

Dr. Benton also discussed the various Board rules that could apply to this situation and mitigating or aggravating factors that could weigh in Ms. Brothers's favor. She noted that Ms. Brothers has not had any prior disciplinary history with the Board and that her license had not been suspended on an emergency basis by the Board. But, she found it concerning that Ms. Brothers failed to initiate CPR on Patient given Ms. Brothers's extensive practice history as an LVN.

In the context of appropriate sanctions, Dr. Benton also discussed the Disciplinary Matrix. With respect to the alleged violation of Code § 301.452(b)(10) (unprofessional conduct), Dr. Benton testified that Ms. Brothers's conduct should be considered a Tier Three offense, Sanction Level I, due to Patient's vulnerability and level of harm (Patient's death). She also testified that there are no mitigating factors to consider. With respect to the alleged violation of Code § 301.452(b)(13) (failure to adequately care for a patient or conform to minimum standards of nursing practice), Dr. Benton testified that she assessed the violation as a Tier Three offense, Sanction Level I, because initiating CPR in an emergency is such a fundamental skill.

Dr. Benton recommended probated suspension of Ms. Brothers's license for two years, including direct supervision in the first year and indirect supervision in the second year, as well as continuing nursing education in CPR, professional accountability, critical thinking, nursing jurisprudence, and ethics.

## **B. Analysis**

Staff asserts that Ms. Brothers should have immediately initiated CPR when she saw the Patient was unresponsive. In support, Staff notes that Ms. Brothers is certified in CPR, and she had the training to appropriately respond. Moreover, Staff contends that Ms. Brothers's assumption that Patient had a DNR order based on the casual demeanor of Patient's assigned nurse was

contrary to acceptable standards of nursing practice. Although Patient's prognosis was poor, she was on hospice care, and her assigned nurse was present, Staff maintains that this is irrelevant, given that Patient did not have a DNR order.

Ms. Brothers asserts that she knew nothing about Patient when she entered Patient's room at the request of Ms. Fraser to check on Patient. Ms. Brothers believed that Patient had a DNR order but admits that she did not ask Ms. Fraser about Patient's plan of care nor did she check Patient's plan of care paperwork herself. Ms. Brothers conceded that not checking Patient's code status prior to her assessment of Patient was counter to her training and education as a nurse.

The evidence in this case demonstrates that Ms. Brothers failed to properly initiate CPR on an unresponsive patient. Ms. Brothers incorrectly assumed Patient had a DNR order even though Ms. Brothers concedes that she knew nothing about Patient prior to entering Patient's room. The preponderance of evidence establishes a violation under either Texas Occupations Code (Code) §§ 301.452(b)(10) or (13).

The ALJ finds that Board rules were also violated by Ms. Brothers's failure to initiate CPR immediately for Patient. Analyzed under Code § 301.452(b)(10) (unprofessional conduct), Ms. Brothers's conduct is best captured by Board Rule 217.12(4) (careless conduct that may endanger a client's life, health or safety).<sup>16</sup> In connection with the violation of Code § 301.452(b)(13) (failing to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm),

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<sup>16</sup> Staff also alleged violations of Board Rules 217.12(1)(A) (carelessly failing to perform nursing in conformity with the standards of minimum acceptable level of nursing practice) and 217.12(1)(B) (carelessly failing to conform to general accepted nursing standards in applicable practice settings). Board Rule 217.12(1)(A) and (B) are general provisions; the specific nursing practice standard that Respondent failed to meet is addressed by Board Rule 217.12(4). Staff did not plead that Board Rule 217.12(1)(A) or (B) addresses an independent violation or gives rise to a different disciplinary action. Therefore, the ALJ does not discuss these provisions separately.

Ms. Brothers's conduct is most closely addressed by Board Rule 217.11(1)(M) (failing to institute appropriate nursing interventions required to stabilize a client's condition).<sup>17</sup>

The argument that Ms. Brothers did not have an affirmative duty to act is unpersuasive in the context of this case. Here, Ms. Brothers, an LVN on duty at the facility where Patient was admitted, testified that she knew nothing about Patient, Patient's respiratory issues, Patient's code status, or Patient's state of responsiveness before she entered Patient's room to conduct an assessment of Patient. Therefore, Ms. Brothers could not have assumed that Patient had been unresponsive for any length of time before she conducted her own assessment of Patient on September 8, 2017. At the moment she detected that Patient was unresponsive, she should have immediately confirmed whether Patient had a DNR order by looking at the information posted on Patient's door, checking Patient's plan of care, and/or contacting Patient's hospice nurse. Finally, the fact that Patient was in hospice does not mitigate the necessity to provide life-saving intervention in the absence of a DNR order or other legal authorization.

At the same time, the ALJ does not find that Ms. Brothers's conduct caused Patient's death. It is unclear how long Patient was unresponsive before Ms. Fraser—who first noticed the unresponsive state but did not initiate CPR—asked Ms. Brothers to check on Patient. And, the evidence does not demonstrate that initiation of CPR by Ms. Brothers would have averted Patient's death.

### C. 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

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<sup>17</sup> Staff also alleged violations of Board Rules 217.11(1)(A) (failing to conform to the applicable laws, rules, and regulations affecting the nurse's current area of nursing practice), 217.11(1)(B) (failing to implement measures to promote a safe environment for clients and others), 217.11(C) (failing to know the rationale for and the effects of medications and treatments and correctly administer the same). As with the analysis of rule violations under Code § 301.452(b)(10), Staff did not plead that Board Rule 217.11(1)(A), (B), or (C) addresses an independent violation or gives rise to a different disciplinary action. The ALJ does not discuss those provisions separately.

safety. Ms. Brothers's violations do not satisfy that condition. As discussed above, Ms. Brothers's violations put Patient at risk of harm because Patient did not receive medical intervention, which may have contributed to her death (though they were not shown to have caused Patient's death).

At the hearing, Dr. Benton testified that, in her opinion, Ms. Brothers'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 Dr. Benton believes Ms. Brothers may have caused Patient's death. However, the preponderance of the evidence did not establish that Ms. Brothers caused or directly contributed to Patient's death. Therefore, the ALJ does not agree with Dr. Benton's assessment that sanctions should be imposed under Tier Three.<sup>18</sup>

That leaves Tier Two, the sanction level that provides for the type of sanctions being sought by Staff against Ms. Brothers. 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 Ms. Brothers's violations and that Tier Two is the appropriate designation for these violations.

Within Tier Two for either failure to conform to minimum standards or unprofessional conduct, the Board must select Sanction Level I or II. In 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).

As aggravating factors warranting a higher sanction, Staff pointed to the vulnerability of Patient and that Patient ultimately died. The ALJ agrees that Patient's vulnerability is an aggravating factor; however, as discussed above, the ALJ does not find that Ms. Brothers's failure to perform CPR resulted in Patient's death. Additionally, CPR is a fundamental skill that any nurse should be ready to apply in the absence of a DNR order.

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<sup>18</sup> The ALJ notes Dr. Benton's assessment of Ms. Brothers's violations as Tier Three offenses would result in far more stringent sanctions, i.e. denial of licensure or revocation of nursing license, than the probated suspension sought by Staff in this case. Given the relief sought by Staff in this case, the ALJ assesses the violations as Tier Two offenses.

As for mitigating factors that might warrant a lower sanction, Dr. Benton testified that, in her view of the evidence, none were present. However, Dr. Benton conceded that Ms. Brothers has practiced for over 40 years and has not had any prior disciplinary history.

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

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

- complete courses in nursing jurisprudence and ethics, documentation, critical thinking, and professional accountability;
- work under direct supervision for a full year, meaning her supervisor is present on the unit when Ms. Brothers 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.

Dr. Benton testified that these conditions and stipulations would address the Board's concerns about Ms. Brothers's training and experience but would allow her to continue working while under probation. The ALJ agrees that these requirements and stipulations are reasonably targeted to address the violations.

Accordingly, the ALJ concludes the Board should sanction Ms. Brothers's conduct under Tier Two, Sanction Level II pursuant to either Code § 301.452(b)(10) or (13), and recommends a two-year probated suspension of Ms. Brothers'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.

#### IV. FINDINGS OF FACT

1. Sharon Brothers was licensed by the Texas Board of Nursing (Board) as a licensed vocational nurse through license no. 69316 on November 19, 1976.
2. On September 8, 2017, Ms. Brothers was employed as a charge nurse at Mesa Vista Inn Health Center (Mesa Vista).
3. On September 8, 2017, Ms. Brothers was assigned as the charge nurse at Mesa Vista for the 500 and 700 Halls.
4. One of the patients (Patient) at Mesa Vista was located in the 800 Hall and assigned to another nurse.
5. Patient was a vulnerable patient.
6. Patient did not have a medical power of attorney on file or a “do-not-resuscitate” (DNR) order on file.
7. Patient was receiving hospice care at Mesa Vista and had an assigned hospice nurse in addition to her assigned nurse on the 800 Hall.
8. During her shift, Ms. Brothers checked on Patient at the request of Patient’s assigned nurse and found Patient unresponsive.
9. Ms. Brothers assumed Patient was dead and had a DNR order.
10. Instead of immediately performing cardiopulmonary resuscitation (CPR) on Patient, Ms. Brothers instructed Patient’s assigned nurse to call Patient’s hospice nurse, doctor, and family.
11. Patient did not receive CPR and died.
12. Mesa Vista investigated the incident, but Ms. Brothers was not placed on a corrective action plan or subject to any disciplinary action.
13. Ms. Brothers has no prior disciplinary history.
14. On May 19, 2021, Staff sent Ms. Brothers a Notice of Hearing. 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.
15. The hearing convened July 27, 2021 before Administrative Law Judge (ALJ) Meaghan Bailey via Zoom videoconferencing. Staff was represented by Assistant General Counsel Jacqueline Strashun. Attorney Elizabeth Higginbotham appeared and represented

Ms. Brothers, who personally attended the hearing. The hearing concluded and the record closed that day. The case was reassigned to ALJ Amy Davis, who listened to the audio recording of the hearing, reviewed the evidence, and prepared this Proposal for Decision.

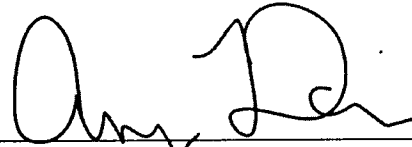
## V. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code (Code) ch. 301.
2. The State Office of Administrative Hearings has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Code § 301.459; Tex. Gov't Code ch. 2003.
3. Ms. Brothers 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 proving its allegations by a preponderance of the evidence, and Ms. Brothers had the burden of proving mitigating factors, if any. 1 Tex. Admin. Code (TAC) § 155.427.
5. Ms. Brothers is subject to sanction because she committed unprofessional conduct by failing to immediately begin CPR when she found the patient to be unresponsive. Code § 301.452(b)(10); 22 TAC § 217.12(4).
6. Ms. Brothers is also subject to sanction because her conduct failed to meet minimum practice standards when she failed to institute appropriate interventions that might be required to stabilize a client's condition. Code § 301.452(b)(13) (now found at Code § 301.452(b)(14)); 22 TAC § 217.11(1)(M).
7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license. Code § 301.453; 22 TAC § 213.33(e).
8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Admin. Code § 213.33 and the Board's Disciplinary Matrix. 22 TAC § 213.33.
9. Ms. Brothers's conduct most appropriately falls in the Tier Two, Sanction Level II of the Disciplinary Matrix under either Code § 301.452(b)(1) or (13). 22 Texas Admin. Code § 213.33(b).

**VI. RECOMMENDATION**

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue a two-year probated suspension on Ms. Brothers's 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 September 27, 2021.**



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**AMY DAVIS  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS**