



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

**DOCKET NUMBER 507-21-2274**

**IN THE MATTER OF § BEFORE THE STATE OFFICE**  
**PERMANENT CERTIFICATE § OF**  
**NUMBER 183988, §**  
**ISSUED TO**  
**NORMA JEAN TELLEZ § ADMINISTRATIVE HEARING**

**OPINION AND ORDER OF THE BOARD**

TO: NORMA JEAN TELLEZ  
C/O ELIZABETH HIGGINBOTHAM,  
ATTORNEY  
HIGGINBOTHAM & ASSOCIATES, LLC  
ONE CASTLE HILLS  
1100 NW LOOP 410, STE 700  
SAN ANTONIO, TX 78213

TREVOR MOORE  
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 that the Respondent's conduct constitutes a violation of Texas Occupations Code §301.452(b)(10) and (13)<sup>1</sup> and that a sanction analysis of either code violation would render the same result for purposes of a sanction determination<sup>2</sup>. The ALJ's sanction analysis concludes that the Respondent's conduct warrants a second tier, sanction level I sanction<sup>3</sup>. The Board agrees with the ALJ's analysis for the Respondent's violation of §301.452(b)(10) and (13).

As found by the ALJ, Respondent's conduct exceeded her scope of practice<sup>4</sup>. Respondent's conduct was carelessness and posed an unreasonable risk of harm to the patient<sup>5</sup>. Further, the conduct was serious, and the Respondent should have been familiar with her scope of practice, given the length of time she was licensed as a nurse in Texas<sup>6</sup>. Further, as noted by the ALJ, there was evidence of a lack of truthfulness/trustworthiness and, without remediation, the Respondent's practice poses a threat to public safety<sup>7</sup>.

The ALJ found some mitigating factors as well. The patient did not suffer actual harm, and the Respondent has no prior disciplinary history with the Board<sup>8</sup>. The Respondent also presented evidence of present fitness to practice<sup>9</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 Warning with Stipulations is the most appropriate sanction in this matter. The ALJ has recommended several specific stipulations<sup>10</sup>, and the Board agrees with the ALJ's suggested stipulations.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should complete courses in nursing jurisprudence and ethics; critical thinking; and medication administration. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future

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<sup>1</sup> See pages 14-15 of the PFD and adopted Conclusion of Law Number 5 of the PFD.

<sup>2</sup> See pages 14-15 of the PFD.

<sup>3</sup> See *id.*

<sup>4</sup> See adopted Finding of Fact Number 17 of the PFD.

<sup>5</sup> See adopted Finding of Fact Number 18 of the PFD.

<sup>6</sup> See page 15 of the PFD.

<sup>7</sup> See *id.*

<sup>8</sup> See adopted Findings of Fact Numbers 19-20 of the PFD.

<sup>9</sup> See page 15 of the PFD.

<sup>10</sup> See pages 15-16 of the PFD.

violations from occurring. The Board also agrees with the ALJ that the Respondent's nursing practice should be indirectly supervised. This supervisory requirement is 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. Also consistent with the ALJ's recommendation, 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 requirements are consistent with 22 Tex. Admin. Code §213.33(e)(3)<sup>11</sup> and are warranted by the nature of the Respondent's violations.

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

### TERMS OF ORDER

#### **I. SANCTION AND APPLICABILITY**

- 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 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.

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<sup>11</sup> 22 Tex. Admin. Code §213.33(e)(3) authorizes a Warning with Stipulations to include remedial education courses and practice for not less than one year under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

### 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 Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.
- B. **A Board-approved course in medication administration** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

- C. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

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).*

## 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 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.

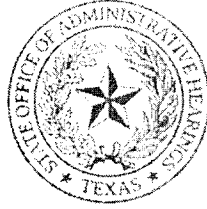
Entered this 20<sup>th</sup> day of January, 2022.

TEXAS BOARD OF NURSING



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



FILED  
507-21-2274  
10/13/2021 11:54 AM  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Carol Hale, CLERK

ACCEPTED  
507-21-2274  
10/13/2021 11:54:32 am  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Carol Hale, CLERK

# State Office of Administrative Hearings

Kristofer S. Monson  
Chief Administrative Law Judge

October 13, 2021

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

**VIA E-FILE TEXAS**

**RE: Docket No. 507-21-2274; Texas Board of Nursing v. Norma Jean Tellez, LVN**

Dear Ms. Thomas:

Please find attached 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).

Sincerely,

A handwritten signature in black ink, appearing to read "Trevor Moore".

Trevor Moore  
Administrative Law Judge

Attachment

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA E-FILE TEXAS**  
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) – **VIA E-FILE TEXAS and INTERAGENCY MAIL**  
Elizabeth Higginbotham, RN, JD, Higginbotham & Associates, LLC, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213 – **VIA E-FILE TEXAS**

P.O. Box 13025 Austin, Texas 78711-3025 | 300 W. 15<sup>th</sup> Street Austin, Texas 78701  
Phone: 512-475-4993 | [www.soah.texas.gov](http://www.soah.texas.gov)

**SOAH DOCKET NO. 507-21-2274**

<b>TEXAS BOARD OF NURSING,</b>	§	<b>BEFORE THE STATE OFFICE</b>
<b>Petitioner</b>	§	
	§	
<b>v.</b>	§	<b>OF</b>
	§	
<b>NORMA JEAN TELLEZ, LVN,</b>	§	
<b>Respondent</b>	§	<b>ADMINISTRATIVE HEARINGS</b>

**PROPOSAL FOR DECISION**

The Staff of the Texas Board of Nursing (Board) seeks to sanction the Licensed Vocational Nurse (LVN) credential held by Norma Jean Tellez (Respondent) based on allegations that Respondent exceeded her scope of practice in administering a medication without proper credentials and medical expertise. Staff argues Respondent should be sanctioned with a Warning with Stipulations. The Administrative Law Judge (ALJ) concludes that Staff proved its allegations by a preponderance of the evidence and recommends the Board issue a Warning with the terms described below.

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

ALJ Trevor Moore of the State Office of Administrative Hearings (SOAH) convened a hearing on the merits on August 5, 2021, via Zoom videoconference. Deputy General Counsel Jacqueline Strashun represented Staff, and attorney Elizabeth Higginbotham represented Respondent. At the conclusion of the hearing, the ALJ left the record open at the request of Respondent to allow her to file certain documents, including performance evaluations unavailable on the date of the hearing. Those documents were filed with Staff, but not with SOAH, and Staff submitted a response. The record closed on August 19, 2021.

There are no additional issues of notice or jurisdiction; therefore, those matters are set out in the Findings of Fact and Conclusions of Law without further discussion here.

## II. STAFF'S FORMAL CHARGES AND APPLICABLE LAW

The Texas Nursing Practice Act, found in chapter 301 of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, unprofessional conduct (Code § 301.452(b)(10)), or practice below minimum standards of nursing care (Code § 301.452(b)(13)). Staff asserted that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to a number of Board rules.<sup>1</sup>

Staff's Formal Charge alleges the following:

**Charge I:** On or about July 11, 2017, while employed as a Licensed Vocational Nurse with CommuniCare Health Center - East Campus, San Antonio, Texas, Respondent inappropriately administered Bicillin injection to co-worker, A.G., who was not a patient at the facility, without an order from a physician. Respondent administered the injection after the patient tested positive for Strep, prior to obtaining an order to do so. Respondent's conduct exceeded her scope of practice in administering a medication without proper credentials and medical expertise.

With respect to its allegation, Staff asserts Respondent engaged in unprofessional conduct by failing to comply with:

- **Board Rule 217.12(1)(A):** carelessly or repeatedly failing, or exhibiting an inability to practice in conformity with minimum standards set out in Board Rule 217.11.<sup>2</sup>
- **Board Rule 217.12(1)(B):** carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings.
- **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.

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<sup>1</sup> The Board's rules, found in title 22, chapters 211 to 228 of the Texas Administrative Code, shall be referred to in the text as "Board Rule \_\_\_\_."

<sup>2</sup> References to substantive provisions of Board Rule 217.12 are to the versions effective in July 2017.

With respect to minimum standards of nursing practice, Staff alleges Respondent did not comply with provisions that require a nurse to:

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

Board Rule 213.33 sets out a disciplinary matrix (Matrix) intended to match the severity of the sanction imposed to the nature of the violation, taking into account mitigating and aggravating factors listed in the Matrix.<sup>3</sup> The 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. Board Rule 213.33 includes another list of factors that the Board and the 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.<sup>4</sup>

Staff had the burden of proving its allegations by a preponderance of the evidence, and Respondent has the burden of proving mitigating factors, if any.<sup>5</sup>

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<sup>3</sup> 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

<sup>4</sup> 22 Tex. Admin. Code § 213.33(c).

<sup>5</sup> 1 Tex. Admin. Code § 155.427.

### III. DISCUSSION

#### A. Evidence

##### 1. Exhibits

Staff offered the following exhibits at the hearing:

1. Computer licensure record, re: Norma Jean Tellez;
2. Notice of Investigation & Opportunity to Show Compliance letter dated July 25, 2017;
3. Formal Charges letter dated December 19, 2018, with attached Formal Charges dated December 17, 2018;
4. Notice of Hearing and Formal Charges dated December 17, 2018;
5. Respondent's answer to allegations, dated July 28, 2017;
- 5a. Respondent's Original Answer to Formal Charges;
6. Medical Records, re: CommuniCare Health Center – East Campus (CommuniCare);<sup>6</sup>
7. Departmental Records, re: CommuniCare;
8. Personnel Records, re: CommuniCare;
9. Policy and Procedure Records, re: CommuniCare;
10. CV/Resume: Kristin Benton, DNP, RN, Director of Nursing, Texas Board of Nursing; and
11. Witness Affidavits:
  - a. Joaquin Littlejohn;
  - b. Manuel Salazar;
  - c. Michelle Campos; and
  - d. Carlos Moreno.

Staff's exhibits were admitted without objection.

Respondent did not offer evidentiary exhibits at the hearing. As noted above, Respondent requested time to file an exhibit post-hearing. Though the exhibit was received by Staff, as evidenced by the response filed by Staff, the exhibit was not filed with SOAH.

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<sup>6</sup> Staff's Exhibit List and the affidavits associated with Exhibits 6, 7, and 8 all refer to "Communicare" Health Center; the underlying documents identify the name of the name as "CommuniCare" Health Center.

## 2. Testimony

Staff presented the testimony of Respondent, Joaquin Littlejohn, Michelle Campos, Manuel Salazar, Alexis Gonzales, and Carlos Moreno. Petitioner testified on her own behalf and presented the testimony of Josue Molina.

### a. Testimony of Respondent

Respondent has been an LVN licensed in Texas (License No. 183988) since 2002. In July 2017, she was employed with CommuniCare Health Center - East Campus, in San Antonio, Texas. On July 11, 2017, Respondent reported for work in the pediatric “pod” about 10 minutes prior to when her 8:00 a.m. shift was to begin. When Respondent arrived, Alexis Gonzales, a medical assistant (MA) under the supervision of Respondent, was already at work. Ms. Gonzales told Respondent that she wasn’t feeling well, had a sore throat, and suspected she had strep throat. Respondent told Ms. Gonzales that if that was the case, she was contagious and should be seen by someone in the family practice section at the clinic as soon as possible. Ms. Gonzales was concerned with seeing a practitioner and possibly not being able to work due to a lack of funds for a co-payment and her lack of available vacation or personal time. Respondent asked another co-worker to see if there was an available appointment for Ms. Gonzales with the clinic’s family practice.

While an appointment with the family practice was being arranged, Respondent began the triage process, taking Ms. Gonzales’s vital signs and performing a swab test for strep throat. The triage procedures were performed in the pediatric pod. Respondent stated did not receive a written or verbal order for a strep test, but performed the test because Ms. Gonzales presented, what Respondent determined, were symptoms for possible strep throat. Respondent confirmed the results of the test were positive for strep throat and she informed Ms. Gonzales. Respondent then administered an intramuscular injection of bicillin to Ms. Gonzales. Respondent did not document the test, the result, or the injection in a medical record for Ms. Gonzales and did not report the results of the test or her administration of the injection to her supervisor or anyone else at

CommuniCare. Respondent did tell Ms. Gonzales that, once she was seen by a practitioner, she should be sure to let them know that she had tested positive and had received a bicillin injection.

Respondent testified the CommuniCare procedures regarding the treatment of CommuniCare staff were not any different from any other patient. As she described, before a patient saw a provider, a nurse would usually take and document her intake vitals, and patients entering CommuniCare would be expected to provide CommuniCare staff with their symptoms and, based on those symptoms, they would be assigned to see a practitioner. Respondent confirmed that she understood bypassing the procedures for patient intake and taking vital signs and performing a strep test on an adult in the pediatric pod without Ms. Gonzales being registered as a patient or seeing a practitioner was outside of her scope of practice as an LVN.

Respondent testified that she did not document the strep test or the administration of the injection to Ms. Gonzales. However, Respondent stated, she performed the test and administered the injection with knowledge that Ms. Gonzales would be seeing a provider in the family practice and she could later document the test and injection in the chart. Respondent informed an MA in the family practice of what she had done to treat Ms. Gonzales and asked to be informed when the chart was open so that the information could be entered. She was not told that Ms. Gonzales had been seen until much later in the afternoon, and only then did the MA request the information regarding the injection of bicillin. Respondent assumed that the information regarding the test and injection had been entered in Ms. Gonzales's chart by the MA. Respondent conceded she had a laptop with her while treating Ms. Gonzales and could have documented the test and the injection contemporaneously to the procedures being performed. Regardless, by not documenting the test or treatment, Respondent testified, she was not trying to hide her treatment of Ms. Gonzales.

At approximately noon on July 11, 2017, Ms. Gonzales was seen by Family Nurse Practitioner (FNP) Juaquin Littlejohn in the family practice at CommuniCare. Respondent stated that at no point did she contact Mr. Littlejohn, explaining that administering a strep test and or a flu test to an employee presenting symptoms was something that was within CommuniCare policy and something that she had done previously.

In explaining her actions, Respondent stated that, though Ms. Gonzales was not yet a patient at CommuniCare when she tested and treated her, she was concerned that, if positive for strep throat, Ms. Gonzales would be contagious and would need to go home. She conceded that, though the injection of bicillin was outside of her scope of practice, she got caught up in trying to expedite the appointment for Ms. Gonzales as opposed to taking the “right action.” She testified that, upon reflection, she realizes she was “playing doctor” and should not have administered medication to Ms. Gonzales. However, in the moment, Respondent testified, she never thought she was practicing outside her scope of practice but was focused on speed and efficiency.

Respondent testified that Manuel Salazar, the Practice Manager for CommuniCare, and Michelle Campos, his assistant, did not speak to her at 12:50 p.m. that day as recorded by Mr. Salazar. She confirmed that at the end of the day she was asked to come to Mr. Salazar’s office to discuss her diagnosis and treatment of Ms. Gonzales. Respondent, Ms. Campos, Mr. Salazar, and Dr. Carlos Moreno were at the meeting. In the meeting, Respondent was told that the injection of Ms. Gonzales with bicillin was outside her scope of practice and she would be terminated from employment at CommuniCare. Ms. Campos then walked Respondent to her desk to gather her things and escorted Respondent out of the facility.

After leaving CommuniCare, Respondent “took a break” and did not work as a nurse for about 8 months. She was hired as an LVN in February 2018 at Gonzaba Medical Group where she works currently. Respondent testified that, at Gonzaba, she works strictly under doctors’ orders. Since the time of the incident in question, Respondent has not taken any continuing or remedial education courses other than those required by her license.

**b. Testimony of Joaquin Littlejohn**

In July 2017, Joaquin Littlejohn was working as an FNP at CommuniCare. In years prior, he had worked as an LVN while in the military and, therefore, is familiar with an LVN’s scope of practice. On July 11, 2017, Mr. Littlejohn was assigned to see Ms. Gonzales. Upon seeing Ms. Gonzales at approximately 12:15 p.m. that day, Mr. Littlejohn was informed that she was an

employee of CommuniCare, had tested positive for strep throat, and had been treated with an injection of bicillin administered by Respondent. He was not provided with any documentation regarding the results of the test, the dose of bicillin that was injected, or any allergy screening that was done in preparation for the injection. With the available information, and noting that Ms. Gonzales was, for the most part, asymptomatic, he ordered a strep test that came back positive. Mr. Littlejohn then ordered symptomatic treatment for her sore throat, but he did not order an antibiotic due to Ms. Gonzales previously receiving an injection of bicillin in an unknown amount. He confirmed that he did not attempt to contact Respondent and determine the bicillin dosage that was administered.

While he was seeing Ms. Gonzales, Mr. Littlejohn told her that receiving a diagnosis and injection without an order from a practitioner was “not the right thing to do,” and she acknowledged she understood. Ms. Gonzales was supposed to return for a follow-up visit the next week. However, she ended up not returning for a follow-up appointment and, after Ms. Gonzales left the exam room, Mr. Littlejohn did not have any further contact with her. He never spoke with Respondent about her treatment of Ms. Gonzales.

Mr. Littlejohn testified that the testing and treatment of Ms. Gonzales by Respondent was inconsistent with the policies and procedures in place at CommuniCare at that time. He stated that, at CommuniCare, an employee complaining of a symptom would ask to be seen, they would be put on the schedule, and the practitioner would perform the test and order treatment. Mr. Littlejohn confirmed that an LVN working on the family practice “side” was allowed, through a standing order, to order a strep test for an adult patient. However, he testified that it is not within an LVN’s scope of practice to treat a patient without an order from a qualified practitioner.

Regarding the treatment of strep with bicillin, Mr. Littlejohn testified that an intramuscular injection of bicillin is not “first line” for treatment of strep throat in adults because there is no need for such an aggressive treatment that involves an intramuscular injection. He also stated that, prior to administering an injection of bicillin, he would need to have an assessment and/or history of allergic reactions for the patient in order to ensure the treatment would not cause an anaphylactic

reaction in the patient that could prove fatal. Mr. Littlejohn explained that the first line of treatment when a step test came back positive would be an oral antibiotic, amoxicillin. He added that, though oral amoxicillin would normally have been prescribed for family practice patients testing positive for strep throat, he did not prescribe amoxicillin for Ms. Gonzales due to her previous injection of bicillin. He also did not prescribe anything to counteract the bicillin she had received from Respondent. On cross-examination, Mr. Littlejohn testified that the statement in his medical record indicating that he prescribed amoxicillin for Ms. Gonzales was incorrect and was included on the form as an automatically prepopulated field.

Following his visit with Ms. Gonzales, Mr. Littlejohn informed Mr. Salazar and Ms. Campos of the situation and authored an incident report regarding his treatment of Ms. Gonzales and the treatment of Ms. Gonzales by Respondent.

**c. Testimony of Michelle Campos**

On the day of the incident in question, Ms. Campos was the supervisor over all the nurses and the MAs at CommuniCare. Ms. Campos has been an LVN licensed in Texas in 2008. She has been employed at the CommuniCare East Campus since 2016 where her duties include supervising the day-to-day operations of the nursing staff and working, as needed, in the front office and in the individual pods. Prior to the date of the incident in question, Ms. Campos had daily contact with Respondent.

Ms. Campos confirmed that she was present at CommuniCare prior to 8:00 a.m. the day of the incident and Respondent did not consult with her prior to testing or treating Ms. Gonzales. About noon on the date of the incident in question, Ms. Campos was summoned to the family practice pod by Mr. Littlejohn. Mr. Littlejohn stated he was seeing Ms. Gonzales and that she had tested positive for strep throat and had been given a bicillin injection by Respondent. He asked Ms. Campos what he should do since she had been treated. Ms. Campos then spoke to Ms. Gonzales who told her she had been tested in the pediatric pod and Respondent had given her the injection of bicillin. Ms. Campos asked Ms. Gonzales who had ordered the injection, and

Ms. Gonzales responded she was not sure, but confirmed Respondent had administered the shot. Confirming that medication had been administered by an LVN prior to a visit with a practitioner, Ms. Campos reported to Mr. Salazar. After relating the situation to Mr. Salazar, they decided they needed to speak with Respondent. At approximately 12:50 p.m. on July 11, 2017, Ms. Campos and Mr. Salazar spoke with Respondent in the pediatric unit, where Respondent explained that Ms. Gonzales was not feeling well, a strip test was given, and the test came back positive. Respondent told Ms. Campos and Mr. Salazar that, because Ms. Gonzales could not afford the co-pay required by a visit with a practitioner, Respondent administered the injection of bicillin.

Ms. Campos confirmed that, per LVN practice and CommuniCare policy, any service provided to a patient should have been entered in the medical record at the time of the visit. This contemporaneous documentation was necessary to allow the members of the medical staff to be aware of a patient's condition and treatment, ensuring that they would receive appropriate care and mistakes in their care would be avoided. Ms. Campos testified that Respondent did not record her testing or treatment of Ms. Gonzales. Ms. Campos did not recall if she or Mr. Salazar had asked Respondent to go back and enter her testing and treatment of Ms. Gonzales in the medical record.

Ms. Campos testified that, when questioned about the treatment of Ms. Gonzales, Respondent was open and honest about what had occurred. She stated that she believed that, by testing for strep throat and administering the bicillin injection prior to Ms. Gonzales seeing a practitioner, Respondent was attempting to act efficiently and expedite treatment. Ms. Campos confirmed that Respondent had acted outside of her scope of practice as an LVN.

**d. Testimony of Manuel Salazar**

As noted above, Mr. Salazar is the Practice Manager at CommuniCare East Campus and was in that position on July 11, 2017. In that role he oversees the medical side of the practice, including staffing and operations.

Mr. Salazar testified that, on July 11, 2017, his office received a call from Mr. Littlejohn wherein Mr. Littlejohn reported he was seeing a staff member that had already been treated with an injection of bicillin. In that call, Mr. Littlejohn confirmed that Respondent had administered the injection and that neither he nor any other practitioner had ordered the injection.

Around noon, after Ms. Campos had spoken with Ms. Gonzales about what had occurred, both Ms. Campos and Mr. Salazar went and spoke with Respondent in the pediatric pod. In that conversation, Respondent stated that Ms. Gonzales was positive for strep but did not have funds for a co-pay. Respondent told Ms. Campos and Mr. Salazar that patients that test positive for strep need to be treated right away and, therefore, she administered the bicillin injection. Though not discussed with Respondent at that time, Ms. Salazar confirmed that CommuniCare had a policy of working with employees to ensure they were treated without having to pay a co-pay on that day. Mr. Salazar confirmed that he was not aware of any other incident of this nature occurring during his time at CommuniCare.

After meeting with Respondent, Ms. Salazar reported his findings regarding what had occurred to CommuniCare's Chief Medical Officer, Dr. Moreno. Subsequently, at the end of the workday, Dr. Moreno called Respondent, Ms. Campos, and Mr. Salazar to meeting. At that meeting, Dr. Moreno told Respondent that she had violated CommuniCare policy and acted outside of her scope of practice when she administered an injection of bicillin to Ms. Gonzales without an order from a practitioner and, therefore, was being terminated from her employment with CommuniCare.

**e. Testimony of Carlos Moreno**

As noted above, Dr. Moreno is the Chief Clinical Officer for CommuniCare. In July 2017, Dr. Moreno was the Vice President and Chief of Clinical Affairs for CommuniCare, overseeing the regulatory aspects of the CommuniCare practice at all of its clinics.

Dr. Moreno testified that, on July 11, 2017, in the late afternoon, he was approached by CommuniCare's regional director for CommuniCare East Campus in San Antonio, Mirna Valentine, concerning an issue with care being provided outside the scope of practice. Ms. Valentine briefed Dr. Moreno was told that an LVN working at the East Campus, Respondent, had administered bicillin to a co-worker without the patient being seen by a provider and without an order from a provider. Dr. Moreno confirmed the injection of bicillin without an order was outside the scope of practice for an LVN. He testified that an LVN did not have the education and experience to make a determination regarding treatment and, in administering treatment without a provider's order, exposed Ms. Gonzales to potential harm and, in turn, exposed CommuniCare to claims of harm due to a licensed employee acting outside the scope of practice.

Dr. Moreno confirmed that, according to CommuniCare records, an inquiry regarding an appointment for Ms. Gonzales was initiated at 7:52 a.m. on the morning of July 11, 2017, and an appointment with Mr. Littlejohn was set for 1:30 p.m. that afternoon. As Mr. Littlejohn had an opening earlier, Ms. Gonzales ended up seeing him about 12:30 p.m. Dr. Moreno confirmed that the first entry in the medical chart for Ms. Gonzales was made by an MA at about 12:20 p.m., prior to her seeing Mr. Littlejohn.

Dr. Moreno testified that, once a person is established as a patient, they have a medical record that can be updated and tracked for both their medical treatment and for billing purposes. As Ms. Gonzales was not yet a patient at the time Respondent administered the injection of bicillin, there was not entry regarding the injection, or the test, in the medical record for Ms. Gonzales. Dr. Moreno also testified that, though CommuniCare is not a free clinic, no one, including employees, are turned away based on their ability to pay.

After confirming the facts regarding the diagnosis and treatment of Ms. Gonzales by Respondent, Dr. Moreno conferred with CommuniCare's Human Resources personnel and it was determined that Respondent had acted outside her scope of practice. At the end of the workday, Dr. Moreno called Respondent, Ms. Campos, and Mr. Salazar to meeting. At that meeting, Respondent acknowledged that she had given the strep test to Ms. Gonzales, that it was positive,

and that she had given Ms. Gonzales the bicillin injection. Dr. Moreno told Respondent that she had violated CommuniCare policy and acted outside of her scope of practice as an LVN when she administered an injection of bicillin to Ms. Gonzales without an order from a practitioner. Dr. Moreno testified that this violation was considered a terminable offense because it was outside the scope of the licensed practice, violated CommuniCare policy, and put the patient and the CommuniCare organization at risk.

**f. Testimony of Alexis Gonzales**

In July 2017, Alexis Gonzales was working at CommuniCare as a MA and worked under Respondent in the pediatric pod. In performing her duties at CommuniCare, Ms. Gonzales received assignments from an LVN or directly from a physician. Due to what she described as both short-term and long-term memory loss, she did not recall reporting to work sick on July 11, 2017, or receiving an injection administered by Respondent.

**g. Testimony of Kristen Benton**

Kristin Benton is a Director of Nursing with the Board and provides expert testimony and consultation. She is a licensed nurse and has practiced in hospitals. In her testimony, and as addressed in more detail in the Analysis section, Dr. Benton discussed the various Board rules that could apply to this situation as well as the Disciplinary Matrix that is used to determine the level of sanctions if a violation of Board rules is found to have occurred.<sup>7</sup> On cross examination, Dr. Benton confirmed her opinion that the intramuscular injection administered by Respondent without an oral or written order of a practitioner posed an unreasonable risk of harm to Ms. Gonzales.

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<sup>7</sup> 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531.

#### **h. Testimony of Josue Molina**

Dr. Molina is a pediatrician and began working at CommuniCare in 2006. He worked with Respondent from 2008 to 2011. He did not work with Respondent after 2011 and has no personal knowledge regarding the incident in question. Dr. Molina testified that, in his time working with Respondent, he had no issues with her working beyond the scope of her LVN practice and had no concerns with her technical knowledge regarding the administration of medication. He stated that, in his professional opinion, when an antibiotic is ordered it may be an oral or injectable. Dr. Molina confirmed that bicillin could be used to treat strep throat.

### **B. Analysis**

#### **1. Conduct Established**

The ALJ finds that Staff proved its Formal Charge by a preponderance of the evidence. The evidence was clear that on July 11, 2017, while employed as a LVN with CommuniCare, Respondent inappropriately administered Bicillin injection to a co-worker, Ms. Gonzales, who was not a patient at the facility and without an order from a physician. Respondent's conduct exceeded her scope of practice in administering a medication without proper credentials and medical expertise. By doing so, Respondent: carelessly failed to conform with nursing standards; engaged in careless conduct that may endanger a patient's health or safety; failed to conform with applicable laws, rules, and regulations; failed to implement measures to promote a safe environment for clients and others; failed to know the rationale for and the effects of medications and treatments and correctly administer the same; and failed to institute appropriate nursing interventions that might be required to stabilize a client's condition or prevent complications. Therefore, Respondent engaged in unprofessional conduct and failed to comply with standards of nursing practice. The ALJ finds that Staff proved conduct supporting disciplinary action under Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (M), and 217.12(1)(A), (B), (4).

## 2. Sanction Analysis

The First Tier of the Matrix for either Code section addresses isolated failures to comply with Board rules concerning unprofessional conduct with no patient risk or adverse effects (Code § 301.452(b)(10)) and practice below the standard of care with a low risk of patient harm (Code § 301.452(b)(13)). In this case, whether Respondent's most serious conduct is analyzed as unprofessional conduct or as a failure to meet the minimum practice standards, a Second Tier, Sanction Level I classification is appropriate under the Disciplinary Matrix given the risk of harm caused by Respondent's administration of an injection of bicillin to Ms. Gonzales without a written or oral order of a practitioner.

The recommended sanction for a Second Tier Offense depends on whether the aggravating and mitigating factors establish that the offense should be considered a Sanction Level I or II. Considering the documentary evidence in the record and the testimony of the witnesses, the ALJ finds the following aggravating factors apply under Board Rule 213.33(c): the potential harm to patients, clients, or the public; evidence of a lack of truthfulness or trustworthiness; practice history; aggravating or mitigating factors including those found in the Matrix; the seriousness of the violation; and, without remediation, the threat to public safety. As described by Dr. Benton, the length of Respondent's practice is considered aggravating, and not mitigating, because Respondent has been licensed as an LVN since 2002 and, in 2017, she should have been very familiar with her scope of practice. The ALJ finds the following mitigating factors apply: no evidence of serious harm to patients; evidence of present fitness to practice; the lack of actual damages, physical, economic, or otherwise, resulting from the violation; and the lack of previous Board discipline. Based on the aggravating and mitigating factors presented in this case, a Second Tier, Sanction Level I is the best fit for the conduct shown.

For violations of Code § 301.452(b)(10) or (13), Second Tier, Sanction Level I includes a Warning or a Reprimand with stipulations. Because this is Respondent's first disciplinary action with the Board, a warning is appropriate. With respect to the stipulations accompanying the Warning, the ALJ agrees with Staff's recommendations: classes in jurisprudence, critical thinking,

and medication administration; a requirement that Respondent provide a copy of the Order and Warning to her employer and cause the employer to send quarterly performance reviews to the Board for one year; and one year of work with indirect supervision under a Registered Nurse or LVN on the premises.

In support of the recommended sanction of a Warning with Stipulations, the ALJ makes the following findings of fact and conclusions of law.

#### IV. FINDINGS OF FACT

1. Norma Jean Tellez (Respondent) was issued Licensed Vocational Nurse (LVN) License No. 183988 by the Texas Board of Nursing (Board) in 2002.
2. In July 2017, Respondent was working as an LVN at CommuniCare – East Campus in San Antonio, Texas (CommuniCare).
3. On July 11, 2017, Respondent reported for work in the pediatric “pod” about 10 minutes prior to the beginning of her 8:00 a.m. shift.
4. When Respondent arrived, Alexis Gonzales, a medical assistant (MA) under the supervision of Respondent, told Respondent that she wasn’t feeling well, had a sore throat, and suspected she had strep throat.
5. Ms. Gonzales was concerned with seeing a practitioner and possibly not being able to work, due to a lack of funds for a co-payment and her lack of available vacation or personal time.
6. Respondent asked another co-worker to see if there was an available appointment for Ms. Gonzales with the clinic’s family practice.
7. While an appointment with the family practice was being arranged, Respondent began the triage process, taking Ms. Gonzales’s vital signs and performing a swab test for strep throat.
8. Respondent did not receive a written or verbal order for a strep test, but performed the test because Ms. Gonzales presented, what Respondent determined, were symptoms for possible strep throat.
9. Respondent confirmed the results of the test were positive for strep throat and she informed Ms. Gonzales.

10. Respondent did not document the test or the result or report the result to her supervisor or anyone else at CommuniCare.
11. Respondent administered an injection of bicillin to Ms. Gonzales without an oral or written order of a practitioner.
12. Respondent did not document the injection or report the administration of the injection to her supervisor or anyone else at CommuniCare.
13. The testing and the administration of the injection of bicillin took place in the pediatric pod at CommuniCare.
14. Respondent told Ms. Gonzales that she should be sure to tell the family practice practitioner of the test results and the bicillin injection once she was registered as a patient and seen.
15. CommuniCare procedures regarding the treatment of CommuniCare staff were not any different from any other patient.
16. Bypassing the procedures for patient intake and taking vital signs and performing a strep test on an adult in the pediatric pod without Ms. Gonzales being registered as a patient or seeing a practitioner was outside of Respondent's scope of practice as an LVN.
17. Administering an injection of bicillin to Ms. Gonzales without an order of a practitioner was outside of Respondent's scope of practice as an LVN.
18. Administering an injection of bicillin to Ms. Gonzales without an order of a practitioner placed Ms. Gonzales at an unreasonable risk of harm. Specifically, such an injection could have caused an allergic reaction or a reaction with other medication Ms. Gonzales was taking.
19. Patient did not suffer actual harm or adverse effects as a result of the injection of bicillin.
20. Respondent has no prior Board disciplinary history.
21. The Staff of the Board opened its own investigation of Respondent's conduct.
22. On May 19, 2021, Staff sent Respondent a Notice of Hearing and Formal Charges containing 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.
23. Administrative Law Judge (ALJ) Trevor Moore of the State Office of Administrative Hearings convened the hearing via Zoom videoconference on August 5, 2021.

24. The record was held open to allow Respondent to file an additional exhibit.
25. The record closed on August 19, 2021.

#### **V. CONCLUSIONS OF LAW**

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. 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. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.
3. Respondent received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.
4. Staff had the burden of proof by a preponderance of the evidence, and Respondent had the burden of establishing any mitigating factors. 1 Tex. Admin. Code § 155.427.
5. Respondent is subject to sanction because she engaged in unprofessional conduct and practice below minimum standards of nursing care, pursuant to Texas Occupations Code § 301.452(b)(10) and (13), and 22 Texas Administrative Code §§ 217.11(1)(A), (B), (C), (M), (O), and 217.12(1)(A), (B), and (4).
6. 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. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).
7. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33(c) and the Board's Disciplinary Matrix at 22 Texas Administrative Code § 213.33(b).

#### **VI. RECOMMENDATION**

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board impose on Ms. Tellez's license a Warning with Stipulations including: classes in jurisprudence, critical thinking, and medication administration; a requirement that Respondent

provide a copy of the Order and Warning to her employer and cause the employer to send quarterly performance reviews to the Board for one year; and one year of work with indirect supervision under a Registered Nurse or LVN on the premises.

**SIGNED October 13, 2021.**

A handwritten signature in black ink, appearing to read 'T. Moore', written over a horizontal line.

**TREVOR MOORE  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS**



FILED  
507-21-2274  
11/4/2021 8:44 AM  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Carol Hale, CLERK

ACCEPTED  
507-21-2274  
11/4/2021 8:48:03 am  
STATE OFFICE OF  
ADMINISTRATIVE HEARINGS  
Carol Hale, CLERK

# State Office of Administrative Hearings

Kristofer S. Monson  
Chief Administrative Law Judge

November 4, 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. 507-21-2274; Texas Board of Nursing v.  
Norma Jean Tellez, LVN**

Dear Ms. Thomas:

I issued a Proposal for Decision (PFD) in this case on October 13, 2021. Please be advised that the time period to file exceptions to the PFD has expired and neither party filed exceptions. Therefore, the PFD is ready for your review, and I recommend it be adopted as written.

Sincerely,

A handwritten signature in black ink, appearing to read "Trevor Moore".

Trevor Moore  
Administrative Law Judge

TM/tt

xc: John Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA EFILE TEXAS**  
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