DOCKET NUMBER 507-20-0896

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 710763,	**§**	**OF**
ISSUED TO	**§**	
OMAR APOLO JACOBO	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: OMAR APOLO JACOBO
5132 SHELL CREEK DR
FT. WORTH, TX 76137

SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
PO BOX 13025
AUSTIN, TX 78711-3025

At the regularly scheduled public meeting on October 20-21, 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 his violations of §301.452(b)(10) and (13).[1]

Licensure suspension, either enforced or probated, or licensure revocation is authorized for a second tier, sanction level II sanction for a violation of §301.452(b)(10) and (13).[2] Based on the findings of the ALJ, the Board agrees with the ALJ that a probated suspension followed by two years of probationary stipulations is the most appropriate sanction in this matter.[3]

The Respondent's conduct was not isolated in nature and resulted in multiple violations affecting a wide spectrum of vulnerable patients.[4] As such, the Respondent's conduct posed a risk of harm to the patients and was serious in nature.[5] Further, the violations indicate a risky pattern of practice.[6] The Respondent also exhibited a lack of truthfulness when he lied about performing a patient's postmortem care.[7] The Respondent also has a prior disciplinary order from 2016.[8] Finally, the Respondent's good professional character is implicated due to Respondent's inability to make appropriate judgments and decisions that could affect patient safety.[9]

The ALJ also found mitigating factors. First, the Respondent has a positive practice history with significant history in critical care; there is evidence of present fitness to practice; the Respondent has practiced since licensure in 2004 and has practiced without subsequent complaint since 2016.[10] The ALJ found, however, that the aggravating factors significantly outweight any mitigating factors,[11] and the Board agrees.

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)(6), that probated suspension with two years of probationary stipulations is the most appropriate sanction in this case.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a medication administration course, an assessment course, and a critical thinking course.[12] The Board also agrees with the ALJ that the Respondent's nursing practice should be

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[1] See pages 27 and 29 of the PFD. Page 27 contains a typographical error regarding the sanction level, but page 29 clarifies that the violations should be characterized as a second tier, sanction level II sanction.

[2] 22 Texas Administrative Code §213.33(b).

[3] See pages 10-13 of the PFD.

[4] See page 27 of the PFD.

[5] See *id.*

[6] See *id.*

[7] See *id.*

[8] See *id.*

[9] See *id.*

[10] See *id.*

[11] See *id.*

[12] 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; see also page 29 of the PFD.

supervised during the probationary period. The Board finds that one year of direct supervision followed by indirect supervision for the duration of the Order should sufficiently ensure the Respondent's safe practice. Supervisory stipulations are intended to prevent additional violations from occurring by ensuring that any deficiencies in the Respondent's practice will be discovered quickly and remediated appropriately. Further, one year of direct supervision followed by at least one year of indirect supervision is consistent with the Board's precedent in cases involving a multi-year disciplinary order. The Board also finds that the Respondent should be required to inform his 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 also consistent with 22 Tex. Admin. Code §213.33(e)(6)[13].

IT IS THEREFORE ORDERED that Registered Nurse License Number 710763, previously issued to OMAR APOLO JACOBO, to practice nursing in the State of Texas is hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

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

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

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

D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

I. COMPLIANCE WITH LAW

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

II. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at:

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[13] 22 Tex. Admin. Code §213.33(e)(6), which authorizes suspension of licensure, probated or enforced, and 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.

http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

III. REMEDIAL EDUCATION COURSE(S)

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

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, 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. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful

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

D. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).

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

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

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

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

D. **Indirect Supervision:** For the remainder of the stipulation/probation period, 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 20th day of October, 2022.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; 507-20-0896 (June 3, 2022)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

June 3, 2022

VIA EFILE TEXAS

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

RE: Docket No. 507-20-0896; Texas Board of Nursing v. Omar Apolo Jacobo, RN

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.

/s/ Srinivas Behara
Administrative Law Judge
State Office of Administrative Hearings

VB/eh

xc: John L. Vanderford, 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**
Omar Apolo Jacobo, 5132 Shell Creek Drive, Fort Worth, TX 76137 - **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-20-0896

TEXAS BOARD OF NURSING, Petitioner	§ §	BEFORE THE STATE OFFICE
v.	§ §	OF
OMAR APOLO JACOBO, RN, Respondent	§ §	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-20-0896

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
OMAR APOLO JACOBO, RN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Omar Apolo Jacobo (Respondent), a Registered Nurse (RN). Staff alleges in nine formal charges that between 2014 and 2017, Respondent failed to conform to the minimum standards of acceptable nursing practice and engaged in unprofessional conduct in the practice of nursing. The Administrative Law Judge (ALJ) concludes that Staff proved most but not all of the allegations by a preponderance of the evidence and recommends that the Board issue an Order containing a two-year probated suspension with appropriate stipulations.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were not disputed and are set out in the Findings of Fact and Conclusions of Law. ALJ Srinivas Behara of the State Office of Administrative Hearings convened the hearing on the merits on from September 15-16, 2021, via Zoom videoconference. Assistant General Counsel John Vanderford represented Staff. Respondent represented himself. Certified Shorthand Reporter Caroline Chapman prepared a transcript, which is the official record of the hearing.[1] The parties agreed to a post-hearing briefing schedule, and, after granting a requested extension, the record closed on April 5, 2022. Respondent did not file a brief.

[1] The hearing was transcribed into two volumes. References to the transcript in this Proposal for Decision (PFD) are abbreviated as "Tr. Vol. 1 at __" or "Tr. Vol. 2 at __."

II. DISCUSSION

A. Applicable Law

Pursuant to Texas Occupations Code (Code) section 301.452(b)(13),[2] the Board may discipline a nurse for failure to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm. Board Rule 217.11[3] discusses minimum acceptable standards of nursing practice, including the following applicable provisions:

- **Board Rule 217.11(1)(A)**: Know and conform to the Texas Nursing Practice Act and Board Rules 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 shall correctly administer the same;
- **Board Rule 217.11(1)(D):** Accurately and completely report and document required matters, including client status; nursing care rendered; physician orders; and administration of medications and treatments;
- **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 217.11(1)(P)**: Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care; and

[2] This provision was moved without change to Code section 301.452(b)(14) in 2021, after the conduct at issue in this case.

[3] 22 Tex. Admin. Code § 217.11. For ease of reference, a Board rule found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code is referred to as "Board Rule ____" in the body of this PFD. This PFD cites to the substantive law in effect at the time of the allegation.

- **Board Rule 217.11(3)(A):** Utilize a systematic approach to provide individualized, goal-directed, nursing care by: performing comprehensive nursing assessments regarding the health status of the client; making nursing diagnoses that serve as the basis for the strategy of care; developing a plan of care based on the assessment and nursing diagnosis; implementing nursing care; and evaluating the client's responses to nursing interventions.

Pursuant to Code section 301.452(b)(10), the Board may also discipline a nurse for unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient or the public. Board Rule 217.12 addresses unprofessional conduct, which includes the following applicable provisions:

- **Board Rule 217.12(1)(A):** Carelessly failing, repeatedly failing, or exhibiting an inability to perform registered nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- **Board Rule 217.12(1)(B):** Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;
- **Board Rule 217.12(1)(C):** Improper management of client records; and
- **Board Rule 217.12((6)(A)):** Misconduct that includes falsifying reports, client documentation, agency records or other documents.

When a nurse has violated the Code sections or a Board rule, the Board has authority to impose a disciplinary sanction.[4] The Board must adopt a schedule of disciplinary sanctions (Matrix) to ensure that a sanction is appropriate for the violation.[5] The Matrix, found at Board Rule 213.33(b), categorizes violations into tiers and sanction levels based on the seriousness of the offense and the risk of harm to patients or the public. Board Rule 213.33(c) also lists factors to be considered when determining the appropriate sanction. When determining the proper sanction, the Board shall consider: (1) whether the person is being disciplined for multiple violations or has previously been the subject of disciplinary action by the Board and has previously complied with

[4] Tex. Occ. Code § 301.4531(a).

[5] *Id.*

applicable law; (2) the seriousness of the violation; (3) the threat to public safety; and (4) any mitigating factors.[6]

Staff had the burden of proving its allegations and aggravating factors by a preponderance of the evidence.[7] Respondent had the burden of proving mitigating factors.[8]

B. Undisputed Facts and Staff's Allegations

The Board licensed Respondent to practice as an RN in 2004.[9] At the hearing on the merits, Staff asserted nine formal charges[10] alleging numerous violations of Board Rules between August 2014 and September 2016, when Respondent was an RN at Texas Health Harris Methodist Fort Worth Hospital (Texas Health). During this time, Respondent was a "float nurse" and primarily worked in the medical-surgical unit (med-surg) but sometimes in the intensive care unit (ICU). Med-surg patients typically included those with serious conditions like pneumonia, infection, or wound care. Although med-surg patients required acute care, med-surg patients were not as resource-intensive as ICU patients, could participate in their own care, and had generally stable vital signs.[11] The following is a summary of the undisputed evidence identified by Staff's Formal Charges.

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[6] *Id.* § 301.4531(b).

[7] 1 Tex. Admin. Code § 155.427; *see Granek v. Texas St. Bd. of Med. Examn'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

[8] 1 Tex. Admin. Code § 155.427.

[9] Staff Ex. 1. In April 2016, the Board and Respondent entered into an Agreed Order containing a Warning with Stipulations and a Fine of $250 against Respondent. The discipline was based on Respondent's plea of guilty to a misdemeanor family violence offense committed in 2005, and his subsequent failure to disclose his criminal history to the Board in a 2008 renewal application. *See* Staff's Fourth Amended Notice of Hearing filed on August 11, 2021.

[10] Staff alleged eleven formal charges in its Fourth Amended Notice of Hearing. Staff did not pursue Formal Charges VIII and XI at the hearing on the merits.

[11] Tr. Vol. 1 at 33.

1. Formal Charge I

Respondent cared for Patient 1 over the night shift of August 10-11, 2014. Patient 1 was admitted to the med-surg unit at Texas Health with an infection known as bilateral lower extremity cellulitis.[12] Patient 1 also had other chronic conditions including congestive heart failure.[13] A physician ordered Patient 1 to take Zoysn, an antibiotic, every six hours.[14] According to the Medication Administration Record (MAR), Respondent began infusing Zosyn to Patient 1 at 21:50 on August 10, and completed the infusion at 00:50 on August 11.[15] The MAR also shows that Respondent began infusing another bag of Zosyn at 01:30 on August 11, which was about two hours early.[16]

Staff alleges Respondent administered Zosyn to Patient 1 in excess of the frequency and/or dosage of the physician's order, which was likely to injure Patient 1 by causing adverse reactions such as kidney injury.

2. Formal Charge II

Patient 1 was also prescribed another common antibiotic, Vancomycin. A trough level is a measure of the amount of a medication in the bloodstream at any given time.[17] A trough level range helps the provider understand the level of medication needed to reach a therapeutic level—based on the trough level, the provider will either increase the dose of medication, decrease the dose, or change the timing of the dose.[18] According to Texas Health policy, the therapeutic trough level for

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[12] Tr. Vol. 1 at 160.

[13] Tr. Vol. 1 at 160; Staff Ex. 6 at 1.

[14] Staff Ex. 5 at 5.

[15] Staff Ex. 5 at 16.

[16] Staff Ex. 5 at 16.

[17] Tr. Vol. 1 at 41, 173.

[18] Tr. Vol. 1 at 175.

Vancomycin was 11 to 20 mg/L.[19] Patient 1 recorded a level of circulating Vancomycin at 21.3. Although Respondent observed the trough level exceed the therapeutic level, he did not call the provider for further instructions and continued the Vancomycin administration to Patient 1. Staff alleges there was potential for harm in that Respondent's conduct denied the physician information necessary to make appropriate decisions for medical care.

Setting aside the trough level issue, Patient 1 also only had one intravenous (IV) site. As indicated in Texas Health's IV Incompatibility Charts, Zosyn and Vancomycin are incompatible drugs, meaning they should not be mixed together.[20] Running Vancomycin and Zosyn through the same IV could cause precipitant formation, and the solid particles could then enter a patient's bloodstream and cause injury.[21] Respondent administered to Patient 1 Zosyn at 21:50 and Vancomycin at 22:10. Despite the incompatibility, Respondent inappropriately administered both medications through the same IV site simultaneously via "y-site" tubing, which allows two different drugs to infuse through primary tubing.[22] Staff alleges Respondent's conduct placed Patient 1 at risk of unnecessary kidney damage.

3. Formal Charge III

Patient 2 had several ailments including acute respiratory failure, chronic obstructive pulmonary disease, asthma, and congestive heart failure.[23] At the time, Patient 2 was also on mechanical ventilation.[24] Based on the conditions, on March 2, 2016, the provider ordered arterial blood gas labs to determine carbon dioxide levels in the blood.[25] In addition, there was an order to

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[19] Tr. Vol. 1 at 41, 173.

[20] Tr. Vol. 1 at 37-39, 173.

[21] Tr. Vol. 1 at 170-173.

[22] Tr. Vol. 1 at 34, 40.

[23] Staff Ex. 6 at 44.

[24] Staff Ex. 6 at 18.

[25] Staff Ex. 6 at 18.

call the provider with any change in vital signs or condition for further orders.[26] During Respondent's shift the night of March 1-2, 2016, Respondent received two arterial blood gas results for Patient 2 but did not notify the provider. The first reading at 23:14 on March 1 revealed that Patient 2 had a low pH level and high carbon dioxide levels.[27] At 01:14 on March 2, Patient 2's blood pH level and carbon dioxide levels turned critical. When the next shift began, Patient 2 was found extremely lethargic and had to be emergently intubated.[28]

Staff alleges Respondent's conduct deprived the physician of vital information required to institute timely medical interventions. Furthermore, Respondent's conduct may have caused changes in the patient's condition to go undetected and untreated.

4. Formal Charge IV

Respondent cared for Patient 3 on the night shift on May 23-24, 2016. The provider ordered two types of insulin for Patient 3: (1) Humalog insulin, which is a rapid-acting insulin to help cover the blood glucose checks that were ordered before meals and at bedtime; and (2) Levemir, a long-acting insulin to be given at bedtime.[29] Patient 3 had a blood glucose check on May 23 at 21:00 resulting in a value of 258, which was an abnormally high value as indicated by the exclamation point next to the value in the chart.[30] On May 24 at 05:00, a blood glucose level of 257 was recorded, which was also high as again indicated by the exclamation point next to the value in the chart.[31] These glucose readings indicated that Respondent missed administering ten total units of Humalog to Patient 3.[32] In addition, Respondent missed administering 20 units of the Levemir dose to

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[26] Staff Ex. 6 at 31.

[27] Staff Ex. 5-1 at 119.

[28] Tr. Vol. 1 at 184.

[29] Staff Ex. 6-1 at 100-02; Tr. Vol. 1 at 189-90.

[30] Staff Ex. 6-1 at 163; Tr. Vol. 1 at 192.

[31] Ex. 6-1 at 163.

[32] Tr. Vol. 1 at 194-95.

Patient 3, ordered for bedtime, resulting in uncontrolled blood sugar for the entire night shift.[33] Respondent documented "missed" on May 23 at 21:00.[34]

Respondent withheld Patient's insulin, did not call the physician, and did not document why he withheld the insulin.[35] Staff alleges that the risks to Patient 3 were high due to Respondent's error, which could have resulted in organ damage, poor circulation in the extremities, gastrointestinal issues, and even blindness.

5. Formal Charge V

On June 14, 2016, Respondent was responsible for Patient 4, who had an order to be turned and repositioned every two hours.[36] Respondent documented in a progress note that Patient 4 had a skin tear to the left back and left groin, but Respondent did not document turning Patient 4.[37]

Staff alleges that subsequent care givers would rely on Respondent's documentation to provide further care to Patient 4 and that Respondent's failure to turn Patient 4 unnecessarily exposed Patient 4 to risk of skin breakdown such as an ulcer.

6. Formal Charge VI

On September 8, 2016, Respondent provided care to Patient 5, who was diagnosed with myocardial infarction, congestive heart failure, and coronary artery disease. Patient 5 had a recent heart attack, and the provider ordered serial troponin enzyme tests three times every six hours on

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[33] Staff Ex. 5-1 at 186; Tr. Vol. 1 at 196-97.

[34] Staff Ex. 5-1 at 186.

[35] Tr. Vol. 1 at 190-92.

[36] Staff Ex. 6-3 at 205-06.

[37] Staff Ex. 5-3 at 379.

September 7, 2016.[38] The troponin enzyme reflects cardiac muscle damage and, if levels were increasing, the provider could confirm the suspected diagnosis of myocardial infarction or know when the damage has ceased.[39] Patient 5 had troponin tests performed at 00:10 and 05:00, which indicated the troponin levels were increasing.[40] Respondent did not complete the third troponin test, which was due at 11:00.[41] Respondent did not carry out the physician's order and did not document why he failed to carry out the third troponin test.[42] The third troponin test in the series was not performed until the night shift at 21:30.[43]

Staff alleges that Respondent's conduct placed Patient 5 at risk of ineffective treatment which could have resulted in a delay of intervention and placed Patient 5 at risk of harm in that subsequent care givers would rely on his documentation to provide further care.

7. Formal Charge VII

On September 13, 2016, at 15:30, Patient 6 died. Respondent was responsible for Patient 6's postmortem care. Postmortem care is a nursing task, which includes removing invasive equipment such as breathing tubes, IVs, drains, and feeding tubes.[44] The nurse is then to give the patient a bed bath, clean the linens, and empty the trash in the room in order to make the patient and room presentable for family visitation.[45] Postmortem care also serves the purpose of preparing the body preliminarily for the funeral home.[46] Although responsible for Patient 6's postmortem care, Respondent did not provide the care through the end of Respondent's shift at 19:00. Alexander

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[38] Staff. Ex. 5-7 at 731; Tr. Vol. 1 at 207.

[39] Tr. Vol. 1 at 208.

[40] Tr. Vol. 1 at 207-08.

[41] Tr. Vol. 1 at 207-08.

[42] Tr. Vol. 1 at 208; Staff Ex. 5-7 at 731.

[43] Staff Ex. 5-7 at 732.

[44] Tr. Vol. 1 at 71-72.

[45] Tr. Vol. 1 at 71-72.

[46] Tr. Vol. 1 at 71-72.

McLaughlin, RN, was the nurse for the next shift, and when he entered Patient 6's room, he discovered the following: Patient 6 was still intubated with a tracheal tube; all IV arterial lines were still sutured to the wrists; electrodes were connected; a blood pressure cuff was still on the arm; a foley catheter was still inserted; the room still had full trash cans; and medical supplies were all around the bedside.[47]

Staff alleges that failing to provide postmortem care could have caused emotional distress for the family and could have delayed release of the body to the funeral home. Further, Staff alleges Respondent falsely documented that the charge nurse on duty was at the bedside at the time of Patient 6's pronounced death, when care was withdrawn, and at the time of discussion with the tissue donation representative. Staff contends that Respondent's conduct resulted in an inaccurate medical record and also called into question Respondent's honesty and trustworthiness.

8. Formal Charge IX

Patient 7 had diagnoses of hypertension, acute respiratory failure, diabetes, anemia, lupus, and chronic kidney disease.[48] Patient 7 had an order that the provider be alerted to any change in condition.[49] Patient 7 had an order of a blood pressure medication, Neo-Synephrine, to be administered on September 19, 2016, at 14:47, with an order to maintain Patient 7's mean arterial pressure between 65 and 80.[50] During Respondent's shift, Patient 7 had two readings below the mean arterial pressure of 65.[51] Respondent was unable to manage Patient 7's blood pressure with the medication as ordered but did not notify the provider of the blood pressure.[52]

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[47] Staff Ex. 5-7 at 767; Tr. Vol. 1 at 119-23.

[48] Staff Ex. 6-8 at 488.

[49] Staff Ex. 6-9 at 512.

[50] Staff Ex. 5-11 at 1075.

[51] Staff Ex. 5-11 at 1065-66, 1075 (showing mean arterial pressure of 62 on 17:30 and 18:14).

[52] Staff Ex. 5-11 at 1075; Tr. Vol. 1 at 227.

Staff alleges that Respondent's conduct denied the physician information necessary to make appropriate decisions for medical care.

9. Formal Charge X

Respondent worked the day shift on September 19, 2016, and cared for Patient 8, who was admitted for polysubstance abuse and overdose.[53] The physician ordered blood cultures to be drawn at 14:33 and to be sent to a lab for bacteria testing over a period of 24 to 48 hours.[54] The cultures allow the care team to identify the bacteria in the blood so that the provider can order the correct antibiotic to treat that particular type of infection.[55] Respondent did not ensure the completion of the blood cultures over four and a half hours through the end of his shift.[56] Patient 8's temperature continued to rise after the blood cultures were ordered.[57] Respondent did not carry out the order timely, and the blood cultures were not obtained until the next shift.[58]

Staff alleges Respondent's inaction could have led to a delay in discovering the bacteria in Patient 8's bloodstream and a delay in ordering and administering the correct antibiotic.

C. Summary of Contested Evidence[59]

Staff had 49 exhibits admitted as evidence and offered four witnesses to testify:

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[53] Staff Ex. 6-10 at 575.

[54] Staff Ex. 6-11 at 620.

[55] Tr. Vol. 1 at 231.

[56] Staff Ex. 5-13 at 1159.

[57] Staff Ex. 5-13 at 1175-76; Tr. Vol. 1 at 231.

[58] Staff Ex. 6-11 at 620.

[59] The following section provides a summary of witness testimony, which can be found in the transcript as follows: (Jessica Altenberg, Tr. Vol. 1 at 33-58); (Rachel Denti, Tr. Vol. 1 at 61-112); (Alexander McLaughlin, Tr. Vol. 1 at 115-49); (Kristin Benton, Tr. Vol. 1 at 154-263, Vol. 2 at 4-172); (Respondent, Tr. Vol. 2 at 173-247).

(1) Jessica Altenberg, RN. Ms. Altenberg was the Charge Nurse at Texas Health from August 10-11, 2014. She testified about the conduct alleged in Formal Charges I and II.

(2) Rachel Denti, RN. Ms. Denti is currently an adult-geriatric primary care nurse practitioner. She was a Charge Nurse Cardiovascular ICU at Texas Health from 2014-2018, when she supervised Respondent. Ms. Denti testified about the allegations in Charge VII regarding Patient 6.

(3) Alexander McLaughlin, RN. Mr. McLaughlin testified about the allegations in Charge VII. At the time, Mr. McLaughlin had been working at Texas Health for two years.

(4) Kristin Benton, DNP, RN. Dr. Benton holds a Doctor of Nursing Practice degree and has been a nurse for 25 years. She has held her current position as the Board's Director of Nursing for about ten years. Dr. Benton discussed the various Board rules that could apply to the allegations in the formal charges, as well as the Matrix that is used to determine the level of sanctions if a violation of Board rules is found to have occurred. Dr. Benton also testified as an expert on minimum standards of nursing practice and identified risks of harm if the allegations were proven true.

Respondent did not offer any exhibits or witnesses but testified on his own behalf. Respondent noted that he had an extensive nursing history with numerous specializations and certifications such as a Critical Care Registered Nurse certification and Fundamentals of Critical Care Services certification. He also completed specialized testing as a Cardiovascular ICU Nurse. For most of the allegations, Respondent did not contest that the conduct occurred, but he denied that his conduct violated any Board rules or carried any risk of harm if the conduct did occur. Respondent described that, at Texas Health, he typically was assigned two patients, but, for most of the allegations in the Formal Charge, he had up to five patients of high acuity on those days.

a. Formal Charges I and II

Ms. Altenberg noted that Respondent was considered a resource nurse and could be utilized to float across different floors for assistance. The med-surg unit dealt with many patients who had infections and wound care, and the two antibiotics at issue for Patient 1 (Zoysn and Vancomycin) were typically used interchangeably around the clock for multiple patients at

Texas Health. According to Ms. Altenberg, both medications were identified on Texas Health's incompatibility chart; it was also commonly known that the drugs were incompatible and should not be used through a y-site. Ms. Altenberg testified that when she was making rounds, she saw Patient 1 had a y-site hooked up and that the alert for the Vancomycin bag was beeping, meaning it was completed. She further noted that Zoysn was still infusing, so she confirmed through the computer system, Lexicomp, that the drugs should not be administered simultaneously, and she brought it to Respondent's attention. She further testified that Respondent initially denied using the y-site but, after continued questioning, Respondent admitted to administering both antibiotics to Patient 1 through the y-site simultaneously. After counseling Respondent, Ms. Altenberg told Respondent to throw away the tubing and further informed Respondent that based on the trough level of 21.3, Vancomycin should not have been infusing in the first place.

Dr. Benton noted that Patient 1 was admitted with an infection known as bilateral lower extremity cellulitis. Patient 1 was also diabetic and suffered from congestive heart failure. A standard dose of Zosyn was ordered to be administered to Patient 1 every six hours. The first infusion began at 21:50 and completed about three hours later at 00:50 (after midnight) on August 18, 2014.[60] Respondent hung another bag at 01:30, which was a little less than four hours later and too soon for the order requiring administration every six hours.[61] According to Dr. Benton, if a nurse finds that there is an order that he or she thinks may not be efficacious, they have a duty to contact the provider to clarify the order. Dr. Benton opined that administering the next dose of Zosyn too soon did not meet the minimum standards of nursing and could have caused kidney injury, particularly for a patient with diabetes. Dr. Benton noted, however, that while Patient 1 had a "slightly elevated" creatine level, which is a measure of kidney function, the measure was within normal limits.

[60] Staff Ex. 5 at 6, 16.

[61] Staff Ex. 5 at 16.

Dr. Benton also opined that administering Vancomycin and Zosyn through the same IV line did not comply with minimum standards of nursing practice. According to Dr. Benton, the two medications were listed on Texas Health's incompatibility charts, which were readily accessible to all nurses and an easy way to identify medications that were incompatible. Dr. Benton noted that if the medications were mixed, a precipitant could form when the two medications contacted each other, which could cause a clot that could enter the patient's bloodstream and cause injury. Finally, Dr. Benton opined that Respondent would have violated nursing minimum standards to administer Vancomycin at all. After receiving a lab value of 21.3 trough level, Respondent should have held off before hanging that dose, or if it had already been hung, put a pause on it and call the provider to let him or her make the decision on next steps.

Respondent did not deny the allegations in Formal Charges I and II. Respondent testified, however, that medications are not restricted to certain times but that the administration windows are very broad—plus or minus two hours from the time ordered for administration. According to Respondent, because the MAR showed that he began infusing the second bag of Zosyn at 01:30 on August 11, he satisfied minimum standards of nursing because he had up to four hours to administer the medication even though the physician's order said to administer it every six hours.[62] Respondent asserted that every other nurse also administered Zosyn to Patient 1 much sooner than the end of the six-hour period. Regarding the y-site administration, Respondent admitted that Texas Health policy and the pharmacist had noted Zosyn and Vancomycin were incompatible, but it was not a violation to administer them through the same line simultaneously based on his understanding of an American Journal of Pharmacists article from 2013, which purportedly stated that Zosyn and Vancomycin were compatible to be infused simultaneously.[63] Respondent also contended that the trough level of 21.3 was not too high but that Texas Health worked with more narrow parameters than what the minimum standards of nursing practice required.

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[62] Staff Ex. 5 at 16.

[63] Respondent offered an abstract of a publication into evidence, but the exhibit was not admitted.

b. Formal Charge III

Charge III relates to Respondent's alleged failure to notify a physician about lab values. Patient 2 had respiratory failure and chronic obstructive pulmonary disease. Patient 2 was unable to transfer oxygen to his lungs because of the respiratory failure and had been retaining too much carbon dioxide, which competes with oxygen in the bloodstream and can cause neurologic effects and lead to coma.[64] Patient 2's arterial blood gas labs were ordered when Patient 2 was in the emergency department, and Patient 2 was then transferred from the emergency department to med-surg. Patient 2 had an order in his medical record for the nurse on duty to notify the provider with any change in vital signs or condition so that further orders could be considered.[65] Patient 2's arterial blood gas labs results came in when Patient 2 was under Respondent's care, and they showed a critically low pH and high carbon dioxide level.

Respondent conceded that it was his responsibility to know about lab values collected on his shift, but he claimed he was never notified of Patient 2's arterial blood gas lab results, so there was no way for him to notify the pulmonologist. He testified that the medical record did not indicate that Respondent was ever notified of the abnormal results. According to Respondent, the respiratory therapist acquires the blood sample, runs the sample, and speaks directly to the physician about the results.

Dr. Benton opined that it would be a violation of minimum nursing standards if Respondent did not notify the physician about the arterial blood gas results. Dr. Benton referenced a Safety Action Learning Tool (SALT) issued to Respondent, which was a form to memorialize safety related incidents at Texas Health. In the SALT, Respondent was notified that it was standard practice for a nurse to check lab results and notify the pulmonologist on duty of critical results for

[64] Tr. Vol. 1 at 182.

[65] Staff Ex. 6 at 31.

further direction, but the physician on shift discovered the blood gas results on his own and had to emergently intubate Patient 2.[66]

c. Formal Charge IV

Charge IV relates to Respondent's failure to administer an insulin medication to Patient 3. According to Respondent, Patient 3 was not in a true hyperglycemic state. Respondent testified that Patient 3 had a sugar level of approximately 250 milligrams per deciliter over an eight-hour period from 09:00 to 17:00, which was appropriate for a diabetic patient in a critical care environment, especially since the insulins were fast-acting. Respondent also testified that he would not give insulin at 05:00 as ordered for Patient 3 because Patient 3 was not going to eat until 07:00 or 08:00, which would have exacerbated the critical care state for Patient 3. Respondent asserted that it was 100 percent within the scope of a critical care nurse to withhold a medication under those circumstances. Respondent contended that his actions were appropriate and that he should have been praised rather than criticized for his actions.

When asked why he did not inform the doctor that the medication was not administered, Respondent asserted that the pharmacy had rescheduled the medication for the next day so there was no need to tell the physician about that decision. Respondent testified the physician on duty had asked that the next time Respondent held insulin he should inform the physician, but there was no issue with his decision at issue.

Dr. Benton noted that Patient 3's medical record showed an exclamation point next to the blood sugar value on May 23, 2016, at 21:00. Respondent noted in the medical record that the insulin was "missed" but did not state a reason.[67] Although the SALT issued to Respondent indicated a "low perception of risk,"[68] Dr. Benton opined that if a patient has sustained high blood

[66] Staff Ex. 15 at 16-17.

[67] Staff Ex. 5-1 at 186.

[68] Staff Ex. 15 at 11.

sugar levels, that patient could experience target organ damage and it could affect microcirculation to the extremities, leading to poor circulation.[69] Further, if there was any kind of minor injury, it could have led to a very serious infection, gastrointestinal issues, or blindness.[70] Respondent was counseled for not administering the medication.[71]

d. Formal Charge V

As alleged in Charge V, Respondent did not "offload" or turn Patient 4 as ordered. Respondent admitted to not turning Patient 4, who had "coded" and required resuscitative care. He testified that in his experience as a critical care nurse, those types of patients are generally not moved because their "metabolic state is so high that even lifting their arm will stimulate the mind enough to cause an increased metabolic state."[72] According to Respondent, increasing the metabolic state left Patient 4 at risk of having additional issues, and "any critical care nurse would unfortunately chuckle at the idea that anybody questions the idea that a patient that is dying needs to be offloaded, if they understand the demands of metabolic states."[73]

Dr. Benton countered that Patient 4 was ordered to be repositioned or "offloaded" every two hours,[74] meaning that the nurse on duty (Respondent) should have shifted Patient 4's body to relieve pressure and reduce the risk of developing a pressure ulcer in bed based on immobility. Dr. Benton analyzed Respondent's failure to document not turning Patient 4, and she opined that it was important for continuity of care for a nurse to ensure that the next caregiver knew what the plan was and what was being done. In this case, without that important information, the nurse on the next shift would not know what position to shift Patient 4.

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[69] Tr. Vol. 1 at 198.

[70] Tr. Vol. 1 at 198.

[71] Staff Ex. 15 at 16-17.

[72] Tr. Vol. 2 at 195.

[73] Tr. Vol. 2 at 197.

[74] Staff Ex. 6-3 at 206.

e. Formal Charge VI

Charge VI pertains to Respondent's alleged failure to notify the physician about lab values. Respondent testified that a phlebotomist is tasked with acquiring troponin lab values (serum levels) and that the phlebotomist communicates directly with the physician about those values. Respondent further noted that Patient 5 had already had myocardial infarction (heart attack) and, without any intervention, the expectation was that that troponin would be elevated.

Dr. Benton testified about the importance of a nurse's responsibility to monitor troponin levels with a heart attack patient such as Patient 5. Specifically, she noted troponin could peak around 24 to 48 hours after the suspected heart attack and return to a baseline anywhere from five to fourteen days after a heart attack.[75] Patient 5's troponin levels were increasing during the first two draws, meaning that more of the enzyme reflecting cardiac muscle damage was present.[76] Given the increasing levels of troponin, Dr. Benton testified that Respondent should have given that information to the provider so the provider could monitor when the damage possibly had ceased,[77] but Respondent failed to carry out the physician's order and did not document any discussion with the provider or note any rationale for failing to carry out the test. According to Dr. Benton, the third troponin test in the series, which was important to the plan of care, was not done until the night shift at 21:30.[78] Dr. Benton opined that Respondent's conduct placed Patient 5 at risk of ineffective treatment which could result in a delay of intervention.

f. Formal Charge VII

Ms. Denti testified about the allegations in Charge VII regarding Respondent's alleged failure to provide appropriate postmortem care to Patient 6. Ms. Denti is currently an adult-

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[75] Tr. Vol. 1 at 207-08.

[76] Tr. Vol. 1 at 208.

[77] Tr. Vol. 1 at 208.

[78] Tr. Vol. 1 at 208; Staff Ex 507 at 731.

geriatric primary care nurse practitioner. She was a Charge Nurse Cardiovascular ICU at Texas Health from 2014 to 2018, when she supervised Respondent. She noted that her unit had about 25 beds and cared for high acuity patients considered the "sickest of the sick."[79]

Ms. Denti testified that during her shift, Patient 6's family had chosen for Patient 6 to be taken off all life support so that he could pass away peacefully. After her shift was over, she learned that Patient 6 died on September 13, 2016, around 15:30. Ms. Denti testified about a progress note written by Respondent at 15:46, which stated the following:

> 15:30 hours. Verified by Omar A. Jacobo, RN, and Leslie McKenzie, RN.· No heart rate, no respiratory rate, no pulse, no signs of life at time.Mia-Chaplin [sic] at bedside. Dr. Watson at bedside to verify asystole. And norespirations confirming at time of death as this.· Rachel Charge nurse at bedside[80]

Respondent wrote an additional note at 16:23 noting the following:

> Dr. Azam at bedside, willing to sign Death Certificate.
> Medical Examiner - 8179205700 Corley, Rob. Released body.
> Robert - Tissue Donations at bedside to speak to family about tissue donation. Family continues free of questions and state they are aware of the current situation, death of patient and need to speak to chaplain regarding funeral arrangement. Rachel Charge nurse and Leslie - clinical nurse facilitator at bedside[81]

Ms. Denti testified that she was not present at bedside at all, and that Respondent's progress notes were false. According to Ms. Denti, she did not know about Patient 6's death until at least an hour after he passed. Ms. Denti noted that Ms. McKenzie was a clinical nurse leader who typically was involved with withdrawal of care or any other complex situation. Ms. Denti learned that at the 18:30 change-of-shift report, Respondent had indicated postmortem care was

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[79] Tr. Vol. 1 at 65.

[80] Staff Ex. 5-7 at 767.

[81] Staff Ex. 5-7 at 767.

completed. Ms. Denti noted that postmortem care is one of the very first things a nurse learns in nursing school. She testified that she later learned Respondent had not completed postmortem care and that Patient 6's family could have been traumatized seeing a dirty room and Patient 6 still hooked up to all tubing and equipment.

Mr. McLaughlin testified that when he arrived on his shift, he had a brief change-of-shift report with Respondent. Respondent informed him that the third patient assigned to Mr. McLaughlin, Patient 6, had passed way. Respondent also stated that all postmortem care had been taken care of and that they were just waiting for the funeral home to come by and pick up the body. Mr. McLaughlin understood that to mean that all postmortem care had been provided, so he started to plan out his care for his other two patients. However, when he arrived at Patient 6's room around 19:00, which was three and a half hours after Patient 6 passed, he observed a regular ICU room. Equipment was still at the bedside, linens were not changed, trash cans were full, and Patient 6 had all invasive lines still connected. According to Mr. McLaughlin, no family was present when it took him 30-40 minutes to perform postmortem care, which impeded his scheduled time for his other two patients.

Respondent testified that he did not remember specifically whether postmortem care was provided but that "[w]hatever was done for [Patient 6] up until that time was appropriate."[82] He claimed there was nothing in the record to refute that Ms. Denti was at bedside and he questioned how she would claim, as a charge nurse, that she was unaware that a patient died during her shift. Respondent also claimed there was no chance of any surprise or emotional distress to Patient 6's family because the family was with Patient 6 at bedside during his decline and when he passed.

As explained by Dr. Benton, if a nurse falsely documents an occurrence in the patient record, it can disrupt patient care because the nurse following that nurse may rely on those records

[82] Tr. Vol. 2 at 207.

to know what to do next.[83] Further, Dr. Benton noted that falsifying documentation called into question a nurse's honesty, and trust is an integral part of nursing practice.[84] According to Dr. Benton, there was a risk of some emotional harm to Patient 6's family because the facility had no limitations on visitation times and they could have arrived to see their loved one deceased but not in the expected presentable and peaceful-looking position.

g. Formal Charge IX

Charge IX relates to Respondent's alleged failure to intervene when Patient 7's blood pressure dropped. Respondent testified that Patient 7 had an appropriate mean arterial blood pressure reading of 60, which according to Advanced Cardiac Life Support standards was sufficient, above a reading of 40, to not only perfuse the brain but also the kidneys. According to Respondent, the kidneys were the "most sensitive organs that [caregivers] must protect" and even if the mean arterial blood pressure dropped below 65 it would be a normal characterization for Patient 7. Respondent testified that there was no note anywhere in the medical record that a physician was concerned about Patient 7's blood pressure and that he would not have notified the physician unless the blood pressure reading dropped to 55.

Dr. Benton countered that Respondent was unable to manage Patient 7's blood pressure with the blood pressure medication (Neo-Synephrine) as indicated by the persistent values outside of the target range. Dr. Benton opined that whether Respondent could not or chose to not maintain the mean arterial pressure within the range of the physician's order, Respondent had an unconditional duty to report the issue to the physician. According to Dr. Benton, failing to do so denied the physician information necessary to make appropriate decisions for medical care.

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[83] Tr. Vol. 1 at 217.

[84] Tr. Vol. 1 at 217.

h. Formal Charge X

Staff alleges Respondent failed to draw blood cultures for Patient 8 and failed to notify the physician of fever and hypertension, which were changes in vital signs and condition. Respondent claimed the physician required him to acquire the blood cultures whenever possible but there was no "stat" or urgency order. Respondent testified that Patient 8's order simply stated, "obtain two blood cultures," and had an open window with no timeframe. According to Respondent, blood cultures would be tainted anyway because Patient 8 was already on antibiotics, and the blood cultures results could take two to three days to obtain. Specifically, Respondent noted that blood cultures were obtained to verify that an antibiotic being utilized is the correct one to use, but they would not get immediate results and it was no rush to obtain them. Respondent stated that the oncoming nurse after his shift did not take that blood culture until two hours after the nurse started the shift, which he took as evidence that the need to obtain the blood culture was not immediate.

Dr. Benton testified that the minimum standards of nursing practice required Respondent to complete the blood cultures within the hour, but they were not obtained until the next shift.[85] Dr. Benton testified that Respondent's failure to timely ensure that these tests were completed could have led to a delay in discovering the bacteria in a patient's bloodstream and a delay in ordering and administering the correct antibiotic.[86] Dr. Benton noted that Patient 8's temperature continued to rise after the blood cultures were ordered, which supported her opinion that Respondent's unexplained delay was unreasonable, dangerous, and violated the minimum standards of nursing practice.[87]

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[85] Tr. Vol. 1 at 237.

[86] Tr. Vol. 1 at 230.

[87] Tr. Vol. 1 at 239.

D. Analysis - Violations

Respondent did not contest or dispute most of Staff's evidence that he engaged in the conduct alleged. The main questions were whether the preponderant evidence demonstrated that Respondent's conduct failed to conform to the minimum standards of acceptable nursing practice and/or constituted unprofessional conduct in the practice of nursing. As described below, Staff met its burden of proof by a preponderance of the evidence on Formal Charges II-V, VII, and IX-X. Each formal charge is addressed in turn.

1. Formal Charge I

Staff alleged that Respondent administered a dose of Zosyn to Patient 1 in excess frequency. A standard dose of Zosyn was ordered to be administered to Patient 1 every six hours, and Staff demonstrated that Respondent administered a second dose of Zosyn a little less than four hours later. Respondent testified, however, that medications are not restricted to certain times and instead that the administration windows could vary between one to two hours from the time ordered for administration. Based on the conflicting evidence presented, there are equal inferences to be drawn that Respondent's second administration of Zosyn was either within or too far outside that allotted time window. Accordingly, Staff did not meet its burden of proof by a preponderance of the evidence to demonstrate that Respondent violated the minimum standards of acceptable nursing practice or engaged in unprofessional conduct in administering the second dose.

2. Formal Charge II

Staff proved by a preponderance of the evidence that after receiving a lab value of 21.3 trough level of Vancomycin for Patient 1, Respondent should have held off before hanging that dose, or if it had already been hung, put a pause on it and called the provider to let him or her make the decision on next steps. Respondent's bare contention that Texas Health's parameters were too narrow was not supported by any credible evidence. Setting aside that Vancomycin should not have

been administered in the first place, Staff also met its burden of proof to demonstrate that Zosyn and Vancomycin were incompatible and should not have been administered simultaneously through a y-site. Texas Health's incompatibility chart designated the medications as incompatible and, as Ms. Altenberg testified, it was common knowledge on their unit that these drugs were incompatible. Respondent's conduct, as proven in Charge II, demonstrated he did not know the rationale for and the effects of Vancomycin, that he carelessly administered the medication, and that he did not implement measures to promote a safe environment for Patient 1. Respondent's conduct violated Board Rules 217.11(1)(A)-(C) and 217.12(1)(A)-(B).

3. Formal Charge III

Respondent admitted that it was his responsibility to know about lab values collected on his shift. Arterial blood gas lab results came in during his shift and he should have reviewed them. The minimum standard required Respondent to assess Patient 2 and bring these critical lab values to the provider's attention to make sure that the provider was aware of the values and ask if there were any additional interventions to order. Respondent did not assess Patient 2 and failed to notify the physician of the critical lab values. Respondent's mismanagement of Patient 2's labs and failure to intervene was careless and violated Board Rules 217.11(1)(A)-(D), (M), (P); and 217.12(1)(A)-(C), (6)(A).

4. Formal Charge IV

Without collaborating with the physician, Respondent withheld insulin administration for Patient 3 as ordered. Respondent's conduct denied the physician information necessary to make appropriate decisions for Patient 3's medical care. Respondent attempted to rationalize his decision by referring to the Patient's condition. However, the preponderant evidence demonstrated that Respondent did not have the discretion to withhold insulin. Moreover, Respondent did not document his decision-making process anywhere in Patient 3's medical record.

Respondent's conduct was careless and violated Board Rules 217.11(1)(A)-(D), (M), (P); and 217.12(1)(A)-(C).

5. Formal Charge V

Patient 4 was ordered to be turned and repositioned every two hours. Staff met its burden by a preponderance of the evidence to demonstrate that Respondent had a duty to comply with the order. Further, regardless of whether Respondent felt it prudent to not move Patient 4, Respondent failed to document offloading and positioning Patient 4, and he did not document his rationale for failing to move Patient 4. Respondent's conduct was careless and violated Board Rules 217.11(1)(A)-(C), (M); and 217.12(1)(A)-(C).

6. Formal Charge VI

Based on the evidence presented, it was unclear whether Respondent or the phlebotomist had the duty perform the troponin test for Patient 5. Respondent credibly testified that at Texas Health, the phlebotomist communicated directly with the physician about those values. Given that equal inferences can be drawn whether Respondent or the phlebotomist should have performed the third troponin test, Staff failed to meet its burden of proof to demonstrate his conduct in failing to perform the tests violated any Board rules.

7. Formal Charge VII

Plainly stated, Respondent's testimony about his care for Patient 6 was not credible. Respondent did not dispute that he failed to provide postmortem care for Patient 6 during his shift. Yet, the undisputed evidence demonstrated that he told both Ms. Denti and Mr. McLaughlin that he completed postmortem care. Ms. Denti was also unequivocal in her testimony that she was not present during pronouncement or bedside when Respondent said she was. Based on the fact that Respondent had already lied about postmortem care to two witnesses, along with Ms. Denti's

denial, Staff proved that Respondent more likely than not falsely documented in the medical record of Patient 6 that Ms. Denti was present at the bedside to verify the time of death after care was withdrawn and present during the discussion of tissue donation. Respondent's conduct was careless, resulted in an inaccurate medical record, and violated Board Rules 217.11(1)(A)-(D); and 217.12(1)(A)-(C), (6)(A).

8. Formal Charge IX

The patient had an order for the provider to be alerted to a change in condition. Regardless of the order, Staff demonstrated it was the standard of care for a nurse to alert a provider to a change in condition. Patient 7's blood pressure was persistently recorded low. Dr. Benton persuasively testified Respondent had an unconditional duty to report the persistent low values to the physician, regardless of Respondent's rationale that the blood pressure was not too low for Patient 7. Respondent's failure to collaborate and intervene in Patient 7's care was careless and violated Board Rules 217.11(1)(A)-(B), (M), (P); and 217.12(1)(A)-(B).

9. Formal Charge X

Staff demonstrated by a preponderance of the evidence that Respondent failed to ensure the completion of the blood cultures for Patient 8 as required. As stated by Dr. Benton, these tests should have been completed within the hour. Although Respondent testified the blood cultures were not urgent or "stat," Respondent did not ensure the completion of the blood cultures over four and a half hours through the end of his shift, and they were not completed until a nurse's next shift. Respondent's failure to order the tests was careless and violated Board Rules 217.11(1)(A)-(C), (M), (P); and 217.12(1)(A)-(B).

E. Analysis - Sanctions

Staff met its burden of proof on eight Formal Charges, which subject Respondent to sanction by the Board under both Code sections 301.452(b)(10) and (13). The Matrix categorizes violations into three tiers, in ascending order of seriousness. Here, when multiple violations are present, the Matrix directs that the most severe sanction recommended for any of the violations should be considered.[88] Whether analyzing the sanction under section 301.452(b)(10) or section (13), a Second Tier, Sanction Level I classification is appropriate under the Matrix.

The First Tier of the Matrix addresses isolated failures to comply with Board rules concerning unprofessional conduct with no patient risk or adverse effects (Code section 301.452(b)(10)) or practice below the standard of care with a low risk of patient harm (Code section 301.452(b)(13)). Staff met its burden of proof to demonstrate multiple violations rather than isolated failures. In addition, Staff proved that Respondent violated several minimum nursing practice standards involving a wide spectrum of vulnerable patients (or "high acuity" as Respondent described). Accordingly, Respondent's conduct involved at least some risk of harm, and the sanction exceeds the First Tier. The Third Tier under Code section 301.452(b)(10) encompasses unprofessional behavior that results in serious harm to a patient or the public, and Third Tier under Code section 301.452(b)(13) is meant to address substandard practice with a serious risk of harm or death that is known or should be known or a significant demonstration of incompetence. The evidence does not show actual, serious harm, and Staff did not argue or allege there was a serious risk of harm or death that was known or should have been known, or a significant demonstration of incompetence. Thus, the Third Tier under any of these Code sections is inappropriate, and Respondent's conduct falls within the Second Tier of the Matrix.

Based on the facts presented, Respondent's conduct is more appropriately considered as a failure to adequately care for patients and conform to the minimums standards of acceptable

[88] 22 Tex. Admin. Code § 213.33(c); Tex. Occ. Code § 301.4531(c)(1).

nursing practice under section 301.452(b)(13). The recommended sanction depends on whether the aggravating and mitigating factors outlined in Board Rule 213.33(c)[89] establish that the conduct should be considered under Sanction Level I or II. Regarding Board Rule 213.33(c)(1), Staff conceded there was no actual harm established for any violations except for possibly Formal Charge III, where Respondent's failure to notify the physician of the patient's critical lab values may have delayed intervention and contributed to the patient's need for emergent intubation. That inference, however, was too speculative and would have required some form of expert testimony to support the inference that Respondent's conduct more likely than not caused any actual harm. As noted above, however, there was potential for harm given the vulnerability of the patients involved. Staff also proved the following aggravating factors in Board Rule 213.33(c) apply: (2) Respondent exhibited a lack of truthfulness when he lied about performing postmortem care on Patient 6; (6) Respondent has a prior disciplinary order from 2016 containing a Warning with Stipulations and a Fine; (9) a sanction would deter Respondent and others from taking action without physician orders or failing to act on physician orders; (13) Respondent committed multiple violations; (14) Respondent's conduct was serious in that he demonstrated a willingness to practice nursing without regard to safety measures and provider's orders while administering IV medications, failing to assess patients, failing to document and notify providers of significant patient status changes including lab values and vital signs, and failing to follow provider orders; (15) threat to public safety, as the violations depict that Respondent engaged in a risky pattern of disregarding safety measures and practicing autonomously without regard to provider orders; and (16) based on the violations, Respondent's good professional character was implicated in that Respondent exhibited an inability to conform his behavior to the applicable Code provisions and

[89] 22 Tex. Admin. Code § 213.33(b)-(c). The following factors in Board Rule 213.33(c) do not apply to the facts presented: (3) evidence of misrepresentation of the nurse's credentials or abilities; (5) evidence of present fitness to practice; (7) actual damages resulting from the violation; and (10) attempts by Respondent to correct or stop the violation. Regarding (12), although Respondent implied that he could have been overworked with being assigned numerous high acuity patients, there was no suggestion that system dynamics at Texas Health contributed to his decision to ignore physician's orders or to fail to notify the physician of lab results. There was no evidence of any continuing education courses under (17). Further, the mitigating and aggravating circumstances in the Matrix do not apply under (11) as they are redundant of other factors already considered.

Board Rules and his conduct depicted a nurse who did not make appropriate judgments and decisions that could affect patients.

Respondent proved the following mitigating factors under Board Rule 213.33(c) apply in his favor: (4) evidence of positive practice history with significant history in critical care; (5) evidence of present fitness to practice; (7) the length of time Respondent has practiced since 2004; and (18) justice requires consideration of the length of time that has passed since the Respondent's violations (six to eight years ago) without any subsequent Board complaints.

Staff seeks a two-year probated suspension of Respondent's RN license as a Sanction Level II. Staff did not prove actual patient harm, and the length of time since the violations is an important mitigating factor. The aggravating factors, however, significantly outweigh any mitigating factors. Specifically, the number of violations with vulnerable patients involved, along with proof of Respondent's untruthfulness and prior disciplinary history, compel a serious sanction. Accordingly, Respondent's sanction falls within Sanction Level II, which identifies the applicable sanction ranges as suspension of license, revocation of license, or request for voluntary surrender. Based on the facts presented, Respondent should receive a Board Order containing a two-year probated suspension with the following conditions requiring him to:

- complete courses in nursing jurisprudence and ethics, medication administration, patient assessment, and critical thinking;
- notify his employers that he is working under a Board order, submit notice of his employment to the Board, and submit quarterly work evaluation forms to the Board;
- work under direct supervision by an RN for a full year, meaning his supervisor is present on the unit when Respondent is working; and
- then work under indirect supervision by an RN for a second year, with a supervisor on the premises but not necessarily on the same unit.

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

III. FINDINGS OF FACT

1. Omar Apolo Jacobo (Respondent) holds Registered Nurse (RN) license No. 710763, issued by the Texas Board of Nursing (Board) on October 21, 2004.

2. In April 2016, the Board and Respondent entered into an Agreed Order containing a Warning with Stipulations and a Fine of $250 against Respondent. The discipline was based on Respondent's plea of guilty to a misdemeanor family violence offense committed in 2005, and his subsequent failure to disclose his criminal history to the Board in a 2008 renewal application.

3. Respondent was an RN at Texas Health Harris Methodist Fort Worth Hospital (Texas Health) between August 2014 and September 2016.

4. Respondent cared for Patient 1, who had congestive heart failure and other ailments, over the night shift of August 10-11, 2014. Patient 1 was prescribed a common antibiotic, Vancomycin. According to Texas Health policy, the therapeutic level for Vancomycin in the bloodstream was 11 to 20 mg/L. Patient 1 recorded a level of circulating Vancomycin at 21.3 mg/L. Respondent observed the level exceed the therapeutic level but did not call the physician to discuss directions and continued the administration to Patient 1. There was potential for harm to Patient 1 in that Respondent's conduct denied the physician information necessary to make appropriate decisions for medical care.

5. Patient 1 also had only one intravenous (IV) site. As indicated in Texas Health's IV Incompatibility Charts, Zosyn (another antibiotic) and Vancomycin are incompatible drugs, meaning they should not be mixed together. Despite the incompatibility, Respondent inappropriately administered both Zosyn and Vancomycin through the same IV site simultaneously via "y-site" tubing. Respondent's conduct placed Patient 1 at risk of harm from precipitant formation in the bloodstream.

6. On March 1-2, 2016, Respondent cared for Patient 2, who was on mechanical ventilation. The provider ordered arterial blood gas labs for Patient 2 to determine carbon dioxide levels in the blood. In addition, there was an order to call the provider with any change in vital signs or condition for further orders. Respondent received two arterial blood gas results for Patient 2 but did not notify the provider. The first reading at 23:14 on March 1 revealed that Patient 2 had a low pH level and high carbon dioxide levels. At 01:14 on March 2, Patient 2's blood pH level and carbon dioxide levels turned critical. When the next shift began, Patient 2 was found extremely lethargic and had to be emergently intubated. Respondent's conduct deprived the physician of information necessary to make appropriate decisions for medical care.

7. Respondent cared for Patient 3 on the night shift on May 23-24, 2016. The provider ordered two types of insulin for Patient 3. During Respondent's shift, Patient 3 had blood glucose resulting in abnormally high values as indicated by the exclamation points next to the values in Patient 3's chart. Respondent withheld Patient's insulin, did not call the physician, and did not document why he withheld the insulin.

8. On June 14, 2016, Respondent was responsible for Patient 4, who had an order to be turned and repositioned every two hours. Respondent documented in a progress note that Patient 4 had a skin tear to the left back and left groin, but Respondent did not document turning Patient 4. Subsequent care givers would rely on Respondent's documentation to provide further care to Patient 4, and Respondent's failure to turn Patient 4 unnecessarily exposed Patient 4 to risk of skin breakdown.

9. On September 13, 2016, Patient 6 died. Respondent was responsible for Patient 6's postmortem care. Respondent had several hours to provide the care but did not perform it and left Patient 6 still intubated with a tracheal tube; all IV arterial lines were still sutured to the wrists; electrodes were connected; a blood pressure cuff was still on the arm; a foley catheter was still inserted; the room still had full trash cans; and medical supplies were all around the bedside.

10. On September 13, 2016, Respondent falsely documented in the medical record of Patient 6 that the charge nurse was present at the bedside to verify the time of death after care was withdrawn and present during the discussion of tissue donation. The charge nurse was not present during those events.

11. Patient 7 had diagnoses of hypertension, acute respiratory failure, diabetes, anemia, lupus, and chronic kidney disease. Patient 6 had an order that the provider be alerted to any change in condition. Patient 6 had an order of a blood pressure medication, Neo Synephrine, to be administered on September 19, 2016, with an order to maintain Patient 6's mean arterial pressure between 65 and 80. During Respondent's shift, Patient 6 had two readings below the mean arterial pressure of 65. Respondent was unable to manage Patient 6's blood pressure with the medication as ordered but did not notify the provider of the blood pressure.

12. Respondent worked the day shift on September 19, 2016, and cared for Patient 8, who was admitted for polysubstance abuse and overdose. The physician ordered blood cultures to be drawn at 14:33 and to be sent to a lab for bacteria testing over a period of 24 to 48 hours. The cultures allow the care team to identify the bacteria in the blood so that the provider can order the correct antibiotic to treat that particular type of infection. Respondent did not ensure the completion of the blood cultures over four and a half hours through the end of his shift. Patient 8's temperature continued to rise after the blood cultures were ordered. Respondent did not timely carry out the order, and the blood cultures were not obtained until the next shift.

13. After an investigation, staff of the Board (Staff) filed Formal Charges against Respondent in October 2019.

14. On October 30, 2019, Staff docketed this case at the State Office of Administrative Hearings (SOAH) in Austin, Texas.

15. On August 11, 2021, Staff sent Respondent its Fourth Amended Notice of Hearing and Formal Charges. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

16. Administrative Law Judge Srinivas Behara of SOAH convened the hearing on the merits on September 15-16, 2021, via Zoom videoconference. Assistant General Counsel John Vanderford represented Staff. Respondent represented himself. Certified Shorthand Reporter Caroline Chapman prepared a transcript, which is the official record of the hearing. The parties agreed to a post-hearing briefing schedule, and, after granting a requested extension, the record closed on April 5, 2022. Respondent did not file a brief.

IV. CONCLUSIONS OF LAW

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

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

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

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

5. Respondent violated the minimum nursing standards and engaged in unprofessional conduct when he engaged in the conduct describe in Findings of Fact Nos. 4-12. Code §§ 301.452(b)(10), (13); 22 Tex. Admin. Code §§ 217.11(A), (B), (C), (D), (M), (P); .12(1)(A), (B), (C), (6)(A).

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. 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, including aggravating and mitigating circumstances, set forth in Texas Occupations Code section 301.4531(b), 22 Texas Administrative Code section 213.33(c), and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(b).

8. Aggravating factors in this case include the following: evidence of potential harm to vulnerable patients; prior disciplinary history; Respondent's lack of truthfulness; deterrent factor of the sanction; existence of multiple violations; the seriousness of the conduct; threat to public safety; and lack of good professional character.

9. Mitigating factors in this case include the following: lack of actual harm; evidence of positive practice; the length of time Respondent has practiced; and the length of time that has passed since the Respondent's violations.

V. RECOMMENDATION

The ALJ recommends that the Board issue Respondent an Order containing a two-year probated suspension with stipulations requiring him to: complete courses in nursing jurisprudence and ethics, medication administration, patient assessment, and critical thinking; notify his employers that he is working under a Board order, submit notice of his employment to the Board, and submit quarterly work evaluation forms to the Board; work under direct supervision by an RN for a full year, meaning his supervisor is present on the unit when Respondent is working; and then work under indirect supervision by an RN for a second year, with a supervisor on the premises but not necessarily on the same unit.

SIGNED June 3, 2022.

SRINIVAS BEHARA
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

FILED
507-20-0896
6/23/2022 10:04 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Jessie Harbin, CLERK

ACCEPTED
507-20-0896
6/23/2022 11:02 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Jessie Harbin, CLERK

State Office of Administrative Hearings

Kristofer Monson
Chief Administrative Law Judge

June 23, 2022

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

VIA EFILE TEXAS

RE: Docket No. 507-20-0896; *Texas Board of Nursing v. Omar Apolo Jacobo, RN*

Dear Ms. Thomas:

Please be advised that the time period to file exceptions to the Proposal for Decision (PFD) issued in the above-referenced hearing has expired and neither party filed exceptions. *See* 1 Tex. Admin. Code § 155.507(b). Accordingly, I recommend that the PFD be adopted as written.

Best regards,

Vasu Behara,
Presiding Administrative Law Judge

CC:

John L. Vanderford, 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

Omar Apolo Jacobo, 5132 Shell Creek Drive, Fort Worth, TX 76137 - VIA EFILE TEXAS

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED
Registered Nurse License Number 710763	§	
issued to OMAR APOLO JACOBO	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of OMAR APOLO JACOBO, Registered Nurse License Number 710763, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(2) & (10), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on April 21, 2016.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received a Baccalaureate Degree in Nursing from the University of Texas-El Paso, El Paso, Texas on August 31, 2004. Respondent was licensed to practice professional nursing in the State of Texas on October 21, 2004.

5. Respondent's nursing employment history includes:

2004-2009	RN	Hospital Corporation of America Plaza Medical Center El Paso, Texas
2005-2006	PRN	El Paso Specialty Hospital - OR El Paso, Texas
2005-2006	PRN	El Paso Day Surgery - OR El Paso, Texas
2006-2007	PRN	William Army Beaumont Medical Center - OR El Paso, Texas
2009-2010	RN	Methodist Mansfield Medical Center - ICU/ER Mansfield, Texas
2010-2011	PRN	Hospital Corporation of America - ICU Fort Worth, Texas
2010-2011	PRN	Epic Health Services - Pediatric In-Home Health Fort Worth, Texas
2011-Present	RN	Texas Health Resources - ICU/ER/PACU/MedSurg Fort Worth, Texas

6. On or about March 30, 2006, Respondent entered a plea of Guilty to ASSAULT CAUSES BODILY INJURY FAMILY MEMBER, a Class A Misdemeanor offense committed on July 9, 2005, in the El Paso County Criminal Court 1, El Paso County, Texas, under Cause No. 20050C14111. As a result of the plea, the proceedings against Respondent were deferred without entering an adjudication of guilt, and Respondent was placed on probation for a period of one (1) year and ordered to pay a fine and court costs. On or about April 12, 2007, the terms of probation under Cause No. 20050C14111 were discharged.

7. On or about February 24, 2008, Respondent submitted a Texas Online Renewal Document Registered Nurse to the Texas Board of Nursing in which he provided false, deceptive, and/or misleading information, in that he answered "No" to the question: "Have you, within the past 24 months or since your last renewal, for any criminal offense, including those pending appeal:

A. been convicted of a misdemeanor?
B. been convicted of a felony?
C. pled nolo contendere, no contest, or guilty?
D. received deferred adjudication?
E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
F. been sentenced to serve jail or prison time? court-ordered confinement?
G. been granted pre-trial diversion?
H. been arrested or any pending criminal charges?
I. been cited or charged with any violation of the law?
J. been subject of a court-martial; Article 15 violation, or received any form of military judgment/punishment/action?"

Respondent failed to disclose that on or about March 30, 2006, Respondent entered a plea of Guilty to ASSAULT CAUSES BODILY INJURY FAMILY MEMBER, a Class A Misdemeanor offense committed on July 9, 2005, in the El Paso County Criminal Court 1, El Paso County, Texas, under Cause No. 20050C14111. As a result of the plea, the proceedings against Respondent were deferred without entering an adjudication of guilt, and Respondent was placed on probation for a period of one (1) year and ordered to pay a fine and court costs. On or about April 12, 2007, the terms of probation under Cause No. 20050C14111 were discharged.

8. In response to Finding of Fact Numbers Six (6) and Seven (7), Respondent admits to the conviction. In response to Finding of Fact Number (7), Respondent further states he was under the assumption "all charges were dropped."

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555 , the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.12(6)(I) & (13).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(2) & (10), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 710763, heretofore issued to OMAR APOLO JACOBO.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

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

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

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

C. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

II. COMPLIANCE WITH LAW

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

III. REMEDIAL EDUCATION COURSE(S)

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

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

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

IV. MONETARY FINE

RESPONDENT SHALL **pay a monetary fine in the amount of two hundred fifty dollars ($250.00) within forty-five (45) days of entry of this Order.** Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

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. Any quarterly period without continuous employment with the same employer for all three (3) months will not count towards completion of this requirement. 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 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 nurse who supervises the RESPONDENT and these reports shall be submitted by the supervising nurse 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) to practice nursing in the State of Texas and RESPONDENT may be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

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

Signed this 28th day of June, 2016

OMAR APOLO JACOBO, Respondent

Sworn to and subscribed before me this 28th day of June, 2016.

SEAL

Notary Public in and for the State of Texas

AFSHEEN AMIRALI FAZALBHAI
My Commission Expires
April 30, 2018

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the28th day of June, 2016, by OMAR APOLO JACOBO, Registered Nurse License Number 710763, and said Order is final.

Effective this9th day of August, 2016.

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