DOCKET NUMBER 507-21-2398

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 562829,	**§**	**OF**
ISSUED TO	**§**	
BRENDA A. LARA	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: BRENDA A. LARA
C/O BENJAMIN P. GARCIA, ATTORNEY
1500 BROADWAY, STE 511
LUBBOCK, TX 79401

HEATHER HUNZIKER
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 her 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 licensure revocation is the most appropriate sanction in this matter.[3]

The Respondent's conduct posed a risk of harm to the patient.[4] The ALJ also found evidence of Respondent's untruthfulness.[5] The Respondent also has five prior disciplinary orders spread across her nursing career related to similar conduct.[6] The Respondent's admission that she still relies on her memory rather than checking for physician's orders, despite knowing that is a required standard of nursing practice, demonstrates a disregard for the laws and rules of nursing practice and a lack of concern for patients' health and safety.[7] The Respondent also committed several violations of the Nursing Practice Act and Board rules.[8] The ALJ also found the patient's vulnerability, the involvement of controlled substances, the seriousness of her conduct, and her lack of good professional character evidenced by poor judgment and non-conformance to professional standards to constitute additional aggravating factors.[9]

Purusant to Tex. Occ. Code §301.4531(c), the Board must consider taking a more severe disciplinary action, including licensure revocation, against an individual who is being disciplined for multiple violations and/or who has previously been the subject of disciplinary action by the Board. In addition to prior disciplinary Board orders of reprimand, voluntary surrender, and stipulations, the Respondent was previously suspended.[10] As stated by the ALJ, the only remaining penalty option is revocation.[11]

The ALJ did not find any mitigating factors.[12]

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e), that licensure revocation is the most appropriate sanction in this case.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 562829, previously issued to BRENDA A. LARA, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

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[1] See pages 20-21 of the PFD.

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

[3] See pages 17-21 of the PFD.

[4] See pages 17-18 of the PFD.

[5] See *id.*

[6] See *id.*

[7] See *id.*

[8] See pages 18-19 of the PFD.

[9] See *id* and adopted Finding of Fact Number 13.

[10] See page 20 of the PFD.

[11] See *id.*

[12] See adopted Finding of Fact Number 14.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure.

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; 507-21-2398 (July 22, 2022)

State Office of Administrative Hearings

Chief Administrative Law Judge

July 22, 2022

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

VIA E-FILE TEXAS

Re: SOAH Docket No. 507-21-2398.TBN; TEXAS BOARD OF NURSING v. BRENDA A. LARA

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 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at www.soah.texas.gov/agency.

Heather Hunziker,
Presiding Administrative Law Judge

Enclosure

CC:

Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) - **VIA E-FILE TEXAS & INTERAGENCY MAIL**
Mary Nastasi and Rose Crampton, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - **VIA E-FILE TEXAS**
Benjamin P. Garcia, Attorney, 1500 Broadway, Suite 511, Lubbock, TX 79401 - **VIA E-FILE TEXAS**

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SOAH Docket No. 507-21-2398 **Suffix: TBN**

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
v.
BRENDA A. LARA

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks revocation of the Registered Nurse (RN) license held by Brenda A. Lara, based on allegations that she violated the Nursing Practice Act (Act)[1] and the Board's rules.[2] The Administrative Law Judge (ALJ) concludes that Staff met its burden and, for the reasons set forth herein, recommends that the Board revoke Ms. Lara's license.

[1] Tex. Occ. Code ch. 301 (Nursing Practice Act (Act)).

[2] 22 Tex. Admin. Code chs. 213 and 217. All citations in this Proposal for Decision are to the substantive provisions in effect at the time of the underlying incident, in July 2019. For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, will be referred to as "Board Rule _____."

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are set out in the Findings of Fact and Conclusions of Law without further discussion here.

The hearing on the merits was held on May 12, 2022, via the Zoom videoconferencing platform, before ALJ Heather D. Hunziker of the State Office of Administrative Hearings (SOAH).[3] Deputy General Counsel Jena Abel represented Staff and attorney Benjamin P. Garcia represented Ms. Lara. The record closed on June 16, 2022, the deadline for filing closing briefs.[4]

II. STAFF'S ALLEGATIONS AND APPLICABLE LAW

Under the Act, the Board is authorized to take disciplinary action against a nurse for, among other things, a violation of the Act, a Board Rule, or a Board order;[5] unprofessional conduct that is likely to deceive, defraud, or injure a patient or the public;[6] or failure to meet minimum standards of nursing practice in a manner that exposes a patient unnecessarily to risk of harm.[7] Staff asserts that

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[3] Ms. Lara did not appear at the original hearing on the merits held on August 2, 2021, as a result of which the ALJ issued an order of default dismissal on August 4, 2021. That default dismissal was subsequently set aside in an order issued August 24, 2021.

[4] SOAH Order No. 7, issued May 13, 2022, held the record open until June 16, 2022, for replies to closing arguments. Staff filed its closing brief on May 26, 2022; Ms. Lara filed her closing brief on June 9, 2022.

[5] Act § 301.452(b)(1).

[6] Act § 301.452(b)(10).

[7] Act § 301.452(b)(13).

Ms. Lara's conduct is grounds for disciplinary action under all three Act provisions, as well as pursuant to Board Rules 217.11 and 217.12.[8]

Board Rules 217.11 and 217.12 address minimum standards of nursing practice and unprofessional conduct; and Staff alleged Ms. Lara is subject to sanction under multiple provisions:

- Board Rule 217.11(1)(A): Failure to know and conform to the Act and Board Rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- Board Rule 217.11(1)(B): Failure to implement measures to promote a safe environment for clients and others;
- Board Rule 217.11(1)(C): Failure to know the rationale for and the effects of medications and treatments and correctly administer them;
- Board Rule 217.11(1)(D): Failure to accurately and completely report and document client status, nursing care rendered, physician orders, and administration of medications and treatments, client responses, and contacts with other health care team members concerning significant events regarding client's status;
- 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): Failing to conform to generally accepted nursing standards in applicable practice settings;
- Board Rule 217.12(1)(C): Improper management of client records;
- Board Rule 217.12(4): Conduct that may endanger a client's life, health, or safety; and
- Board Rule 217.12(11)(B): Violating an order of the Board, or carelessly or repetitively violating a state or federal law relating to the practice of

[8] Staff Ex. 4.

registered nursing or violating a state or federal narcotics or controlled substance law.[9]

When a nurse has violated the Act or Board Rules, the Board is required to impose a disciplinary sanction.[10] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[11] The Disciplinary Matrix categorizes violations into tiers and sanction levels, based on the seriousness of the offense and risk of harm to patients or the public; and it lists certain aggravating and mitigating factors that must be considered.[12] Both the Act and the Board Rules direct the Board to consider taking a more severe disciplinary action, including revocation of the nurse's license, when the nurse is being disciplined for multiple violations or has previously been the subject of disciplinary action by the Board.[13]

Board Rule 213.33(c) includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction.[14] The relevant factors include:

(1) evidence of actual or potential harm to patients, clients, or the public;

(2) evidence of a lack of truthfulness or trustworthiness;

(4) evidence of practice history;

(6) whether the person has been subject to previous disciplinary action by the Board or any other health care licensing agency in Texas or

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[9] Staff Ex. 4.

[10] Act § 301.453(a).

[11] Board Rule 213.33(b).

[12] Board Rule 213.33(b)-(c).

[13] Act § 301.4531(c); Board Rule 213.33(b).

[14] Board Rule 213.33(c).

another jurisdiction and, if so, the history of compliance with those actions;

(7) the length of time the person has practiced;

(9) the deterrent effect of the penalty imposed;

(10) attempts by the licensee to correct or stop the violation;

(11) any mitigating or aggravating circumstances, including those specified in the Disciplinary Matrix;

(13) whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders;

(14) the seriousness of the violation;

(15) the threat to public safety; and

(16) evidence of good professional character as set forth and required by Board Rule 213.27.[15]

Staff had the burden of proving its allegations and aggravating factors by a preponderance of the evidence.[16] Ms. Lara had the burden of proving mitigating factors.[17]

Staff charges that Ms. Lara engaged in the following conduct in violation of the Act and Board Rules (the specific acts are discussed further in the next section):

- Charge I: On or about July 6 and 7, 2019, while employed with Southern Specialty Rehab and Nursing (Southern Specialty), Ms. Lara withdrew Tramadol[18] from the emergency kit for patient R.D.[19] without a

[15] Board Rule 213.33(c).

[16] 1 Tex. Admin. Code § 155.427.

[17] 1 Tex. Admin. Code § 155.427.

[18] Tramadol is a pain medication classified as a Schedule IV narcotic, which is a controlled substance. Tex. Health & Safety Code § 481.032; 43 Tex. Reg. 614 (Feb. 2, 2018).

[19] For purposes of protecting the identity of the patient involved in the events giving rise to this case, this Proposal

physician's order, violating Board Rules 217.11(1)(A), (1)(B), (1)(C), and 217.12(1)(A), (1)(B), (1)(C), (4); and

- Charge II: On or about July 6 and 7, 2019, while employed with Southern Specialty, Ms. Lara withdrew Tramadol from the emergency kit for patient R.D.[20] but failed to document the administration and/or wastage[21] of the Tramadol in patient R.D.'s Medication Administration Records (MAR) and/or nurses' notes, violating Board Rules 217.11(1)(A), (1)(B), (1)(D), and 217.12(1)(A), (1)(B), (1)(C), (11)(B).

III. DISCUSSION

A. BACKGROUND

Ms. Lara received her RN license (license no. 562829) in Texas on August 31, 1990.[22] Ms. Lara was disciplined by the Board on previous occasions, resulting in Agreed Orders in July 1994, December 1998, September 2003, July 2005, and March 2012.[23] Her previous offenses involved failing to administer and/or document medication and/or medical assistance; failure to meet minimum standards of nursing practice and unprofessional conduct; and falsification of care documentation, while nursing at four different facilities.[24] In several instances, the charges were the same as those in this matter: withdrawing medication for patients

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for Decision refers to the patient by their initials. Staff Ex. 4 at 6.

[20] Staff Ex. 4 at 6.

[21] As discussed below and explained by witness Dusty Charles Fleming, "wastage" is what is done with unused, residual medication after administration of the prescribed amount.

[22] Staff Ex. 1.

[23] Staff Ex. 7.

[24] Staff Ex. 7.

without physician's orders and withdrawing medication without documenting its administration.

Ms. Lara stipulated to withdrawing Tramadol from Southern Specialty's emergency kit for patient R.D. on July 6 and 7, 2019.

B. EVIDENCE

Staff offered ten exhibits, all of which were admitted, and called as witnesses Dusty Charles Fleming, Quentin Brady, and Staff's expert, Timothy R. Sherman. Ms. Lara testified on her own behalf and did not offer any exhibits.

1. Testimony of Dusty Charles Fleming, Administrator of Southern Specialty

Mr. Fleming is a licensed nursing facility administrator and supervised all departments at Southern Specialty in July 2019, when Ms. Lara was employed there as an RN. He testified that the facility kept medication for each day's use on a cart that was under lock and key, with a separate lock and key to a box within the cart for narcotics. The facility's pharmacy also stocked an emergency kit for nurses to access outside of regular hours. He said the keys to the cart, the narcotics box, and the emergency kit were passed between shift nurses at the end of each shift; so only the shift nurse, with the keys, had access at any given time.

Mr. Fleming testified that the pharmacy kept records of which medications were pulled from the emergency kit, including how much medication and by whom. He explained that nurses were required to chart the giving of medication and were

required to document and have witnessed any medication wastage. Mr. Fleming explained that "wastage" is what is done with unused, residual medication after administration of the prescribed amount.

Mr. Fleming testified that patients' records and physician's orders were kept in Point Click Care (PCC); and nurses would access PCC, where they could see if a prescription had been discontinued. He explained that nurses could also ask questions of another nurse on the shift or call the Director of Nursing or Assistant Director of Nursing. Mr. Fleming said if a nurse got only a verbal order, rather than a written one, it was the nurse's responsibility to enter a written order into the tracking system—immediately, or during that shift at the latest.

Mr. Fleming stated the pharmacy records showed that Ms. Lara had withdrawn Tramadol from the emergency kit once per day for patient R.D., on July 6 and 7, 2019. He examined the patient's record and found that the previous order for Tramodol—which had been prescribed for over a year—was discontinued on June 3, 2019, via an order that Tramodol no longer be given. He concluded that Ms. Lara had withdrawn the Tramadol without a physician's order. Further, Mr. Fleming testified that he found no documentation of any administration of the Tramadol, nor any pain assessment or other documentation of the patient's need for pain medication, nor any documentation of wastage, on those dates. He said there was no documentation, whatsoever, of what happened to the withdrawn Tramadol. Mr. Fleming stated that, as a result of Ms. Lara's withdrawal of Tramadol without an order and subsequent failure to document what was done with it, she was suspended and, ultimately, terminated.

Mr. Fleming went through Staff Exhibit 6, Southern Specialty's records, which includes among other items: patient R.D.'s MAR, facility policies, incident self-report, medication withdrawal records, and an employee timekeeping record for Ms. Lara showing she worked July 6-7, 2019. Among other observations, Mr. Fleming noted Southern Specialty's policy required:

- Nurses to immediately chart the administration of medication in the MAR.[25]
- All current medications and dosage schedules to be listed on the patient's MAR.[26]
- If a controlled medicine was removed from its packaging and not administered, that it be "wasted to where the drug is unable to be used and/or destroyed and disposed of" and that such wastage be documented on the controlled accountability sheet for the medication and witnessed by a nurse.[27]
- Medication to be given if there was a clear, signed order of a person lawfully authorized to prescribe.[28]

Mr. Fleming also noted the following:

- Tramadol is not listed in the current prescriptions for patient R.D. as of July 8, 2019.[29]
- The Order Audit Report for patient R.D. shows his Tramadol prescription was discontinued on June 3, 2019.[30]

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[25] Staff Ex. 6 at 28, paragraph 5.

[26] Staff Ex. 6 at 29, paragraph 11.

[27] Staff Ex. 6 at 29, paragraph 17.

[28] Staff Ex. 6 at 31.

[29] Staff Ex. 6 at 49.

[30] Staff Ex. 6 at 54.

2. Testimony of Quentin Brady, Registered Nurse

Mr. Brady, who has been a registered nurse for 25 years, was the Director of Nursing at Southern Specialty in July 2019. Ms. Lara reported to him. He testified that, in 2019, Southern Specialty was still using paper charting; so, orders would be in the electronic PCC system and any administration would be on paper. Mr. Brady testified that once a prescription was canceled, it would no longer appear in the MAR—this was to prevent accidental administration. He said the MAR books stayed with the cart for immediate charting/documenting of all medication administration. He added that nursing notes of pain assessments were done through the electronic system; and, if a patient had pain that was not normal for them, the nurse would fill out a special "S-BAR" form to notify the physician.

Mr. Brady testified that nurses were required to have a physician's order to give medication, and it was the nurse's responsibility to check for the order. He said the pharmacy was notified whenever a nurse withdrew medicine, for the pharmacy to check for the doctor's order. However, nurses could access the medication from the emergency kit *before* the pharmacy ran its check (for example, after hours).

Mr. Brady stated that the pharmacy reported a discrepancy to him in July 2019, wherein Tramadol had been withdrawn twice over a weekend, by a single nurse, for a single patient, R.D., without any physician's order. Therefore, he said, he checked the MAR for a current order for Tramadol and found none. Mr. Brady said he then questioned patient R.D., who reported that he had received no pain medication over the weekend and the nurse assigned to him was Ms. Lara.

Mr. Brady noted that there was no S-BAR or progress note in patient R.D.'s chart for any changing pain condition. Mr. Brady observed that the Tramadol was withdrawn under patient R.D.'s name, so if R.D. was charged for it but it was not given to him then that could result in fraudulent charges.

Mr. Brady testified that when he questioned Ms. Lara about the Tramadol on the day immediately following her weekend shift, she told him she must have forgotten to document its administration.

Mr. Brady testified that he was taught in nursing school that "if you didn't document it, you didn't do it"; otherwise, the next nurse cannot know it happened, and might accidentally double dose the patient. He said Tramadol is a narcotic; and he explained that nurses must always get another nurse to witness wastage when a narcotic is involved. He said medication is supposed to be charted when it is withdrawn and again if and when it is wasted.

Mr. Brady noted that patient R.D. had orders for Tylenol and Advil, so Ms. Lara could have given the patient one of those for pain and then called the physician about Tramadol, but she told him she had not attempted to contact the physician. Mr. Brady noted that, as a result of a tracheotomy, patient R.D.'s medication had to be crushed up and administered to him through a "g-tube" into his gastro-intestinal tract; so, he conceded that patient R.D. might not have been aware of whether Tramadol was administered to him, especially among his numerous other prescribed medications.

Mr. Brady explained that patient R.D.'s July 2019 MAR shows no pre-fabricated line for Tramadol because it was not prescribed at that time; therefore, to document an administration of Tramadol, Ms. Lara would have had to add another sheet to the MAR, which is not part of Staff Exhibit 6.[31]

3. Testimony of Timothy R. Sherman, MSN, APRN, FNP-C

Mr. Sherman is a Registered Nurse and Advanced Practice Registered Nurse licensed to practice in Texas, and he works for the Board as a consultant. His duties include consulting on investigations and providing educational workshops to nurses; and he has been involved in drafting the Board's rules. Mr. Sherman is familiar with the Act and the Board Rules and uses them in his daily work. He was tendered and accepted as an expert in nursing.

Mr. Sherman reviewed the formal charges and exhibits and listened to the testimony presented at the hearing. He testified that:

- To be compliant with minimum standards, a nurse would need an order to administer medication.
- If the nurse believes a patient needs medication there is no order for, the nurse should seek out a physician or an Advanced Practice Registered Nurse to prescribe something further.
- Just because a patient previously had a prescription for a certain drug does not mean that the patient will not have adverse reactions to it—the health status of the patient could have changed, the drug could not be recommended long-term, or the physician could have concerns about side-effects or interactions with other drugs.

[31] Staff Ex. 6 at 8-10.

- A nurse is required to create a documentation record so future team members have a complete and accurate record to provide continuing care for that patient.
- Narcotics are controlled substances because they have been found to be abused; and when a nurse removes a controlled substance from inventory, the nurse is responsible for documenting what happened to it.
- It is beyond the scope of nursing practice for a nurse to continue administering a drug, including Tramadol, that has been discontinued by the physician.

4. Testimony of Brenda Lara

Ms. Lara admitted withdrawing Tramadol for patient R.D. on July 6 and 7, 2019. And she admitted she did not check whether there was a current physician's order for Tramadol for patient R.D. on those dates. Ms. Lara testified that there had been such a physician's order for that patient several months prior, before she went on a leave of absence, but she failed to check whether it was still valid after she returned from leave. Ms. Lara said she was unaware that patient R.D.'s Tramadol prescription had been discontinued while she was away. She stated that she wished she had checked for an order, because then "we wouldn't be here now;" but she acknowledged that it was her typical practice to rely on her memory as to whether there was an order in place when administering medications to patients. She agreed it was not a good idea for her to rely on her memory of what was prescribed, rather than checking for an order after she returned from leave; and she agreed that a discontinued order for medication is not the same as a current order.

Ms. Lara testified that she had administered the Tramadol because patient R.D. was in pain, and to do otherwise would have resulted in violations of the patient's rights to pain relief. Ms. Lara stated she did not think she needed to report patient R.D.'s pain complaint to his physician because it was not new; and she asserted that "[w]e were specifically told not to call the practitioners or doctors except between 8-5." She said that she crushed the Tramadol up and administered it to patient R.D. through his g-tube; and she reiterated that she did not take it herself. She pointed out that, if she had wanted to take the narcotics herself, it would have made more sense to withdraw the medication from the cart, because no picture is taken of the person withdrawing medication from the cart, in contrast to the emergency kit.

Ms. Lara testified that she has "gotten into trouble for not documenting in the past and learned her lessons about it." She avowed that whenever she administered medication in 2019, she always documented it. She stated there was no wastage of the Tramadol because she had administered it. Ms. Lara observed that documentation for narcotics is always the last page of the MAR but page 6 of 6 of patient R.D.'s MAR was not included in the evidence, of which she stated, "It's missing. That's conspicuous by it's absence." She said she was "told that there was a MAR page that was removed—where they back-dated the discontinuance of the order." She asserted that she documented the pain level with the Tramadol administration on the missing page 6; but she acknowledged she did not complete an S-BAR. However, on cross examination, Ms. Lara agreed that Tramadol would not have appeared on any of the six pages of the MAR because it had been

discontinued prior to that time; and to document a new (or discontinued, as it were) medication, she would have had to add a blank MAR page to write it in.

Ms. Lara acknowledged she has had prior Board orders, one of which involved issues with her administration of drugs. She said she does not think what she did was likely to injure the patient, and she thinks she can continue to provide good patient care.

C. ANALYSIS

1. Sanctionable Conduct

a) Charge I: Withdrawing Medication Without Valid Physician's Order

In Charge I, Staff alleged that Ms. Lara withdrew medication from the medication emergency kit for patient R.D. without a physician's order. Staff asserted that this conduct was likely to injure the patient—in that the administration of medication without a valid physician's order could result in the patient suffering from adverse reactions.

The evidence established that the hospital's protocols and nursing standards both required Ms. Lara to obtain and document a physician's order before administering medication to a patient. The ALJ finds the evidence established that Ms. Lara withdrew medication without a physician's order, and Ms. Lara's action was likely to injure the patient involved. Ms. Lara's conduct violated Board Rules

217.11(1)(A), (1)(B), (1)(C), and 217.12(1)(A), (1)(B), (1)(C), (4); therefore, she is subject to disciplinary action under Act sections 301.452(b)(10) and (13).

b) Charge II: Failure to Document the Administration and/or Wastage of Medication

In Charge II, Staff alleged that Ms. Lara withdrew medication from the emergency kit for patient R.D. but failed to document the administration and/or wastage of the medication in the patient's MAR and/or nurses' notes. Staff asserted that this conduct was likely to injure patient R.D., in that subsequent caregivers would rely on the lack of documentation to further medicate the patient, and this conduct placed the hospital in violation of Texas's Controlled Substances Act.[32]

The evidence established that the hospital's protocols and nursing standards both required Ms. Lara to document the administration or wastage of medication in the patient's MAR and/or nurses' notes. The ALJ finds the evidence established that Ms. Lara failed to document any administration or wastage of the Tramadol medication withdrawn for patient R.D. on July 6 and 7, 2019; therefore, Ms. Lara failed to document administration/wastage of medication. The ALJ finds, further, the evidence established that such conduct involved a controlled substance and was likely to injure the patient involved. Ms. Lara's conduct violated Board Rules 217.11(1)(A), (1)(B), (1)(D), and 217.12(1)(A), (1)(B), (1)(C), (4), (11)(B);

[32] Tex. Health & Safety Code Ch. 481 (Controlled Substances Act).

therefore, she is subject to disciplinary action under Act sections 301.452(b)(10) and (13).

2. Disciplinary Matrix and Sanction Analysis

The ALJ finds that Staff established violations that subject Ms. Lara to sanction by the Board. With respect to unprofessional or dishonorable conduct subject to sanction by the Board under Act section 301.452(b)(10), Ms. Lara violated Board Rules 217.11(1)(A), (1)(B), (1)(C), and (1)(D). With respect to failure to meet minimum standards of nursing practice subject to sanction by the Board under Act section 301.452(b)(13), Ms. Lara violated Board Rules 217.12(1)(A), (1)(B), (1)(C), (4), and (11)(B). Ms. Lara withdrew medication without valid a physician's order and failed to document administering or wasting controlled substances.

Considering penalty factor 1 under Board Rule 213.33(c):[33] While there was no evidence to establish that Ms. Lara's actions or inactions caused actual harm to anyone, the evidence does establish that her conduct had the potential to harm a patient because (1) administration of Tramadol without a valid physician's order could result in the patient suffering from adverse reactions or interactions; and (2) without documentation of the drugs the patient received and when those drugs were administered, the patient's next nurse could administer medications that would cause adverse effects. Such potential re-administration was especially possible with patient R.D., whose g-tube and high number of different medications

[33] Board Rule 213.33(c)(1) (evidence of actual or potential harm to patients, clients, or the public).

made him less likely to be personally aware of which medication was administered to him and when.

Considering penalty factor 2:[34] There is evidence of untruthfulness, in that Ms. Lara provided conflicting testimony concerning whether she documented, or forgot to document, the Tramadol administration and pain assessment.

Considering penalty factors 4, 6, 7, 9, and 10:[35] Several of Ms. Lara's five prior orders spread across her long nursing career related to the same unprofessional conduct—withdrawing medication without a physician's order and failing to document or falsely documenting administering medication or treatment—that has now occurred again. Ms. Lara freely admitted that she typically relies on her memory rather than checking for physician's orders, despite knowing that is a required standard of nursing practice. This pattern of misconduct shows a disregard for the laws and rules of nursing practice, and a lack of concern for patients' health and safety. Ms. Lara's careless and routine repetition of previously penalized conduct indicates that the previous penalties had no effect on her nursing practice.

Considering penalty factors 11 and 13:[36] Ms. Lara committed several violations of the Act, encompassing numerous Board Rules. The repetition of

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[34] Board Rule 213.33(c)(2) (evidence of lack of truthfulness or trustworthiness).

[35] Board Rule 213.33(c)(4), (6), (7), (9), (10) (evidence of practice history, prior disciplinary action, the length of time the person has practiced, deterrent effect of the penalty imposed, and attempts by the licensee to correct or stop the violations).

[36] Board Rule 213.33(c)(11), (13) (mitigating or aggravating circumstances, and whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders).

events, the prior discipline for the same conduct, the patient's vulnerability (vis-à-vis the tracheotomy and g-tube) and the involvement of a controlled substance are all aggravating circumstances for penalty under Act sections 301.452(b)(10) and (13). Ms. Lara did not present any evidence of mitigating circumstances.

Considering penalty factors 14 and 15:[37] Ms. Lara's conduct is a serious patient safety concern because her failure to document the Tramadol (narcotic) administration to patient R.D. placed him at a risk of overdose if it was inadvertently re-administered. Her continuation of her dangerous practices after prior orders involving the same issues, and her admission that she typically does not check for a physician's order before administering medication, represent a serious threat to public safety. Additionally, Ms. Lara's mishandling of Tramadol, a controlled substance, exposed Southern Specialty to violation of the Controlled Substances Act.

Considering penalty factor 16:[38] Ms. Lara has decades of nursing experience, and she professes to have good intentions; yet, she has been repeatedly penalized for the same dangerous practices that she freely admits are still typical for her. The evidence shows that Ms. Lara is not able to practice nursing in an autonomous role. Her acts of poor judgment and non-conformance to professional standards do not show good professional character.

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[37] Board Rule 213.33(c)(14)-(15) (seriousness of the violations and the threat to public safety).

[38] Board Rule 213.33(c)(16) (evidence of good professional character as set forth in Board Rule 213.27).

Both the Act and the Board Rules direct the Board to consider taking a more severe disciplinary action, including license revocation, because Ms. Lara is being disciplined for multiple violations and has previously been the subject of disciplinary action by the Board for the same violations.[39]

Ms. Lara's violations of Act section 301.452(b)(10) resulted in serious risk to a patient or to public safety; therefore, they are Second Tier offenses under the Disciplinary Matrix.[40] The aggravating factors establish that these offenses should be considered Sanction Level II, the recommended sanction for a which is license suspension or revocation. Ms. Lara's violations of Act section 301.452(b)(13) are also Second Tier offenses under the Disciplinary Matrix, because they put her patient at risk of harm.[41] The aggravating factors establish that these offenses should be considered Sanction Level II, the recommended sanction for a which is license suspension or revocation. In addition to orders of reprimand, voluntary surrender, and stipulations, Ms. Lara was previously suspended. The only remaining penalty option is revocation, which the aggravating factors warrant. After reviewing the guidelines set out in the Board's Disciplinary Matrix and the evidence pertinent to the relevant penalty factors, the ALJ recommends revocation of Ms. Lara's license.

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[39] *See* Act § 301.4531(c); Board Rule 213.33(b).

[40] Board Rule 213.33(b).

[41] Board Rule 213.33(b).

3. Recommended Sanction

Accordingly, the ALJ recommends the Board find Ms. Lara's conduct to be Second Tier, Sanction Level II offenses under Act sections 301.452(b)(10) and (13). The ALJ recommends revocation of Ms. Lara's RN license. In support of the recommended sanction, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. Brenda A. Lara was issued Registered Nurse (RN) License No. 562829 by the Texas Board of Nursing (Board) in 1990.

2. On or about July 12, 1994, Ms. Lara received an agreed order of reprimand, imposing stipulations on her nursing practice, as a result of her failure to meet minimum standards of nursing practice and unprofessional conduct on several occasions—falsely documenting home health nursing visits—in December 1992.

3. On or about December 8, 1998, Ms. Lara received an agreed order of probated suspension, with a minimum two-year probation of her nursing license, as a result of her failure to meet minimum standards of nursing practice and unprofessional conduct while nursing on numerous occasions from 1994-1995, relating to: (1) the administration and documentation of medications and physician's orders, (2) the reporting of patients' conditions, and (3) the administering of prescribed patient testing and nursing interventions.

4. On or about September 26, 2003, Ms. Lara received an agreed voluntary order to surrender her nursing license, as a result of her failure to meet minimum standards of nursing practice and unprofessional conduct on numerous occasions in 2001. Her conduct included: failing to assess neurological status of patients when they were admitted following a car

accident; failure to take vital signs of a patient under sedation; failure to obtain consent for sedation of a patient; failure to document administration of and responses to medications; and failure to document a patient's conditions.

5. On or about July 21, 2005, Ms. Lara received an agreed order reinstating her nursing license, with stipulations.

6. On or about March 20, 2012, Ms. Lara received an agreed order of reprimand, with stipulations on her nursing license, as a result of her failure to meet minimum standards of nursing practice and unprofessional conduct, relating to treatment of a patient while nursing on October 28, 2009. Her conduct included denying the patient medication and exposing him to emotional and/or psychological harm.

7. On July 6-7, 2019, Ms. Lara worked as an RN at Southern Specialty Rehab and Nursing in Lubbock, Texas.

8. While working at Southern Specialty Rehab and Nursing, Ms. Lara withdrew Tramadol, which is a Schedule IV controlled narcotic used to treat pain, from the emergency kit for patient R.D. on July 6, 2019, and July 7, 2019.

9. Patient R.D. did not have a current physician's order for Tramadol. The physician's order for Tramadol had been discontinued on June 3, 2019.

10. Ms. Lara did not document, in Medication Administration Records (MAR) or in nurses' notes, the administration of Tramadol to patient R.D. on July 6, 2019, or July 7, 2019, or the wastage of Tramadol on those dates.

11. On March 11, 2022, staff of the Board (Staff) sent Ms. Lara a 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.

12. Administrative Law Judge (ALJ) Heather D. Hunziker of the State Office of Administrative Hearings convened the hearing on the merits on October 25, 2021, via the Zoom videoconferencing platform. Deputy General Counsel Jena Abel represented Staff and attorney Benjamin P. Garcia represented Ms. Lara. The record closed on June 16, 2022, the deadline for filing closing briefs.

13. Aggravating factors related to Ms. Lara's conduct include the multiple events, serious risk of harm to patients, previous disciplinary history for the same conduct, and the involvement of controlled substances.

14. There are no mitigating factors.

V. 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. Ms. Lara 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 of the allegations of misconduct and aggravating factors. Ms. Lara had the burden of proof by a preponderance of the evidence of mitigating factors. 1 Tex. Admin. Code § 155.427.

5. Ms. Lara is subject to sanction for withdrawing controlled substances without valid physician's orders, conduct that was likely to injure the patient. Code § 301.452(b)(10), (13); 22 Tex. Admin. Code §§ 217.11(1)(A), (1)(B), (1)(C), and 217.12(1)(A), (1)(B), (1)(C), (4).

6. Ms. Lara is subject to sanction because of her failure to document administering a controlled substance in a patient's MAR and/or nurses'

notes, conduct that was likely to injure the patient and deceive the hospital pharmacy and place it in violation of the Texas Controlled Substances Act. Code § 301.452(b)(10), (13); Health & Safety Code Ch. 481; 22 Tex. Admin. Code §§ 217.11(1)(A), (1)(B), (1)(D) and 217.12(1)(A), (1)(B), (1)(C), (4), (11)(B).

7. 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).

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the Board's Disciplinary Matrix.

9. The Board may also consider any aggravating and mitigating circumstances set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board revoke Ms. Lara's Registered Nurse license.

SIGNED JULY 22, 2022.

ALJ Signature(s):

Heather Hunziker,

Presiding Administrative Law Judge

FILED
507-21-2398
9/2/2022 4:56 PM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Carol Hale, CLERK

ACCEPTED
507-21-2398
9/6/2022 10:26:19 am
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Carol Hale, CLERK

State Office of Administrative Hearings

Chief Administrative Law Judge

September 2, 2022

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

VIA E-FILE TEXAS

Re: SOAH Docket No. 507-21-2398.TBN; Texas Board of Nursing v. Brenda A. Lara

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). Therefore, the Administrative Law Judge recommends that the PFD be adopted as written.

Heather Hunziker,
Presiding Administrative Law Judge

CC:

Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - VIA E-FILE TEXAS
Mary Nastasi and Rose Crampton, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - VIA E-FILE TEXAS
Benjamin P. Garcia, Attorney, 1500 Broadway, Suite 511, Lubbock, TX 79401 - VIA E-FILE TEXAS

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered License Number 562829 issued to BRENDA A. LARA	§ § §	AGREED ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that BRENDA A. LARA, hereinafter referred to as Respondent, Registered License Number 562829, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on November 22, 2011, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code. Respondent appeared in person. Respondent was represented by Christopher Malish, Attorney at Law. In attendance were Mary Beth Thomas, PhD, RN, Director of Nursing, Executive Director's Designee; John F. Legris, Assistant General Counsel; Linda Laws, BSN, MSN, RN, Advanced Practice Nurse Consultant; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Kathy Duncan, RN, Investigator.

Respondent waived notice and hearing, and agreed to the entry of this Order offered on January 3, 2012, by Katherine A. Thomas, MN, RN, FAAN, Executive Director, subject to ratification by the Board.

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 an Associates Degree in Nursing from Methodist Hospital, Lubbock,

Texas, on June 1, 1990. Respondent was licensed to practice professional nursing in the State of Texas on August 31, 1990.

5. Respondent's nursing employment history includes:

9/90-06/92	Staff RN	Methodist Hospital Lubbock, Texas
6/92-4/96	Case Manager	Great Plains Home Health Lubbock, Texas
6/96-3/97	Director of Nurses	Med-Care Home Health Agency Pharr, Texas
4/97-10/98	Field Registered Nurse	Girling Home Health Agency San Antonio, Texas
3/98-2/99	Triage Nurse	United Health Care Bloomington, MN
11/99-2/00	Staff RN	August Health Care Lubbock, Texas
10/99-2/00	Surveyor	University of Montana Missoula, Mt
2/00-10/00	Charge nurse	Mineral Community Hospital Superior, Montana
10/00-12/00	Charge nurse	Evergreen Nursing Home Missoula, MT
1/01-11/01	ER Nurse	Edinburg Regional Hospital Edinburg, Texas
4/02-6/02	Charge Nurse	Benders Terrace Lubbock, Texas
7/02-9/02	Charge Nurse	Riverside Health Care Center Missoula, Montana
9/02-4/03	Patient Care Coordinator	Village Health Care Missoula, Montana

Respondent's nursing employment history continued:

4/03-10/03	Float RN	Community Medical Center Shiprock, New Mexico
11/03-2/04	ER RN	Browning Hospital

		Shiprock, New Mexico
4/04-5/04	ER RN	Indian Health Services Shiprock, New Mexico
6/04-8/04	ICU RN	Elite Travel Shiprock, New Mexico
12/04-11/06	ER RN	Indian Health Services Crownpoint, New Mexico
3/07-4/08	Office Manager	Unknown
4/08-2/09	Psychiatric RN	Rio Grande State Center Harlingen, Texas
2/09-Present	RN	Unknown

6. On July 12, 1994, Respondent was issued the sanction of Stipulations by the Board of Nurse Examiners for the State of Texas. A copy of the July 12, 1994, Agreed Order, Finding of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

7. On December 8, 1998, Respondent's license to practice professional nursing in the State of Texas was suspended, with suspension stayed, and Respondent was placed on probation by the Board of Nurse Examiners for the State of Texas. A copy of the December 8, 1998, Agreed Order, Finding of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

8. On September 26, 2003, the Board accepted the voluntary surrender of Respondent's license to practice professional nursing in the State of Texas. A copy of the September 26, 2003, Agreed Order, Finding of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

9. On or about July 21, 2005, Respondent's license to practice professional nursing was Reinstated with Stipulations, by the Board of Nurse Examiners for the State of Texas. A copy of the July 21, 2005, Agreed Order, Finding of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

10. At the time of the initial incident, Respondent was employed as a Psychiatric RN with Rio Grande State Center, Harlingen, Texas, and had been in this position for one (1) year and six (6) months.

11. On about October 28, 2009, while employed as a Staff Nurse, with Rio Grande State Center, Harlingen, Texas, Respondent allegedly repetitively confronted Patient JV after he stated to leave him alone, including telling him that he could do what he wanted to but that he was not getting the "pill". Respondent's conduct was likely to injure the patient in that it exposed the patient unnecessarily to a risk of experiencing emotional and/or psychological harm.

12. In response to the incidents in Finding of Fact Number Eleven (11), Respondent states that JV had a history of drug seeking, and had been banging his head after being denied medication which was not due and that she went out to talk with Patient JV after learning from another staff member that J.V. was demanding to have his Ativan. She states that she explained to the patient that she would contact the physician to see if he could have something else for anxiety such as Benadryl, but he began yelling at her using foul language. She states she was trying to verbally redirect him and calm him down, but to no avail.

13. Formal Charges were filed on August 23, 2011.

14. Formal Charges were mailed to Respondent on August 24, 2011.

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 violations of Section 301.452(b)(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A)&(1)(M).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered License Number 562829, heretofore issued to BRENDA A. LARA, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL 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.

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable

to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It 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. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete 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 program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

IT IS FURTHER AGREED, that 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 shall 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 have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and 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 action, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 13 day of January, 2012.

Brenda A. Lara

BRENDA A. LARA, Respondent

Sworn to and subscribed before me this 13th day of January, 2012.

SEAL

WILLIAM AVERETT
Notary Public, State of Texas
My Commission Expires 03/07/2015

Notary Public in and for the State of Texas

Approved as to form and substance.

Christopher Malish, Attorney for Respondent

Signed this 19 day of Jan, 20

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 13th day of January, by BRENDA A. LARA, Registered License Number 562829, and said Order is final.

Effective this 20th day of March, 2012.

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

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS
****

In the Matter of License Number 562829	§	REINSTATEMENT
issued to BRENDA ANN LARA	§	AGREED ORDER

On this day came to be considered by the Board of Nurse Examiners for the State of Texas, hereinafter referred to as the Board, the Petition for Reinstatement of registered nurse license number 562829, held by BRENDA ANN LARA, hereinafter referred to as Petitioner.

An informal conference was held on March 1, 2005, at the office of the Board of Nurse Examiners, in accordance with Section 301.464, Texas Occupations Code.

Petitioner appeared in person. Petitioner was represented by Christopher Malish, Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; James W. Johnston, General Counsel; Anthony L. Diggs, MSCJ, Director of Enforcement; Paul Longoria, Investigator; Jon Teisher, Investigator; and Diane E. Burell, Investigator.

FINDINGS OF FACT

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

2. Petitioner waived notice and hearing, and consented to the entry of this Order.

3. Petitioner received a Diploma in Nursing from Methodist Hospital, Lubbock, Texas, in May 1990. Petitioner was originally licensed to practice professional nursing in the State of Texas on August 31, 1990.

4. Petitioner's professional employment history includes:

8/90 - 10/91	GN/Staff Nurse	Methodist Hospital Lubbock, Texas

Professional employment history continued:

10/91 - 9/92	Home Health Case Manager	Visiting Nurses Lubbock, Texas
8/92 - 1/93	RN/Home Health	Kimberly Quality Care Lubbock, Texas
1/93 - 1/93	RN/Home Health	Calvert Home Health Lubbock, Texas
1/93 - 5/95	Care Manager/Home Health	Great Plains Health Services Lubbock, Texas
6/95 - 10/95	RN/Home Health	Health Care Unlimited McAllen, Texas
11/95 - 11/96	Quality Assurance Nurse/ Office Manager	MedCare Home Health Edinburg, Texas
12/96 - 1/97	Unknown	
2/97 - 3/98	RN/Home Health	Healing Hands Home Health San Antonio, Texas
3/98 - 2/99	Staff Nurse/Telephone Triage	United Health Care San Antonio, Texas
3/99 - 9/99	Unknown	
10/99 - 2/00	Surveyor	University of Montana Missoula, Montana
2/00 - 1/01	Charge Nurse	Mineral Community Hospital Superior, Montana
1/01 - 11/01	ER Staff Nurse	Edinburg Regional Hospital Edinburg, Texas

Professional employment history continued:

12/01 - 3/02	Staff Nurse	Integrated Health Services Lubbock, Texas
3/02 - 7/02	Unknown	
7/02 - 9/02	Charge Nurse	Riverside Health Care Center Missoula, Montana
9/02 - 4/03	Patient Care Coordinator	Village Health Care Missoula, Montana
4/03 - 10/03	Float Nurse	Community Medical Center Missoula, Montana
6/04 - 8/04	ICU Staff Nurse	Shipprock Hospital Farmington, New Mexico
11/03 - 12/04	ER Staff Nurse	Browning Hospital Farmington, New Mexico
12/04 - present	ER Staff Nurse	Crownpoint Healthcare Crownpoint, New Mexico

5. On July 12, 1994, Petitioner was issued the sanction of Stipulations by the Board of Nurse Examiners for the State of Texas. A copy of the July 12, 1994, Agreed Order, Findings of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

6. On December 8, 1998, Petitioner's license to practice professional nursing in the State of Texas was suspended, with the suspension stayed, and Respondent was placed on probation by the Board of Nurse Examiners for the State of Texas. A copy of the December 8, 1998, Agreed Order, Findings of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

7. On September 26, 2003, the Board accepted the voluntary surrender of Petitioner's license to practice professional nursing. A copy of the September 26, 2003, Agreed Order, Findings of Fact, and Conclusions of Law is attached and incorporated, by reference, as a part of this Order.

8. On or about September 21, 2004, Petitioner submitted a Petition for Reinstatement of License to practice professional nursing in the State of Texas.

9. Petitioner presented the following in support of her petition:

9.1. Letter, dated September 3, 2004, from Gary Hachadourian, PhD., Farmington, New Mexico. Dr. Hachadourian states Petitioner was a patient of his in psychotherapy during July and August 2004. The reasons for her half-dozen visits were personal and not related to her professional status. There was no diagnosis pertinent to her ability to work. Dr. Hachadourian is not aware of any problems in her most recent assignment in New Mexico, nor does he know of any reason why she could not practice nursing safely and competently.

9.2. Letter of support, dated September 2, 2004, from Reue Verbus, RN, Farmington, New Mexico. Ms. Verbus states she has been Petitioner's Supervisor for the last year as she has worked different Emergency Rooms for IHS System. Petitioner is consistent, dependable and accurate in carrying out responsibilities to a successful conclusion. She can be counted on to be level headed and effective, and to achieve results in an emergency situation. Petitioner is correctly charting her assessments and continues to chart effectively throughout her care of patients. Petitioner recognizes the need for accurate documentation in the evaluation process. She has shown her upstanding skills in the Emergency Room and cares for her patients and treats them with the utmost respect. Ms. Verbus would recommend Petitioner for any position that she may apply for.

9.3. Letter of support, dated September 12, 2004, from Carol G. Mayon, RN, BSN, Lubbock, Texas. Ms. Mayon states she has known Petitioner since 1990. Petitioner has matured through years of experience working as a registered nurse in Texas and Montana. She understands the importance of accurate and thorough documentation. Petitioner is conscientious and willing to seek assistance and/or continuing education when given unfamiliar assignments. She is stable and capable to work as a registered nurse in the State of Texas, and is very dedicated to her patients.

9.4. Letter of support from Mary Higgins, RN, Hartley, Iowa. Ms. Higgins states she worked with Petitioner in Edinburg, Texas, in the year 2000. At that time, Petitioner performed her duties as a registered nurse. She was a stable registered nurse and was able to perform her duties.

9.5. Letter of support, dated February 28, 2004, from Karen Muich, RN, Acting Director of Nursing, Crownpoint Healthcare, Crownpoint, New Mexico (Indian Health Services), since December 2004. Petitioner functions as a Registered Nurse in the Emergency Room department. She performs at a satisfactory level and practices within the boundaries of facility policies and procedures.

9.6. Letter of support, dated February 25, 2005, from Sarah Morlang. Ms. Morlang states she has been working with Petitioner for the past several months. Petitioner has excellent Emergency Room skills and Ms. Morlang would feel very comfortable having her by her side in any trauma situation. Petitioner has very good bedside manners and is very compassionate with the patients.

9.7. Letter of support, dated February 25, 2005, from Henry Holmes, RN, BSN. Mr. Holmes states Petitioner has been working in the Crownpoint Emergency Room for the last several months. Mr. Holmes states she is a very efficient ER nurse with good assessment skills. Petitioner is very well organized with her charting and her nursing care.

9.8. Documentation of twenty (20) Type 1 contact hours.

CONCLUSIONS OF LAW

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

2. Pursuant to Section 301.467, Texas Occupations Code, the Board may refuse to issue or renew a license, and may set a reasonable period that must lapse before reapplication. Pursuant to 22 TEX. ADMIN. CODE §213.26, the Board may impose reasonable conditions that a Petitioner must satisfy before reissuance of an unrestricted license.

ORDER

IT IS THEREFORE AGREED, subject to ratification by the Board of Nurse Examiners, that the petition of BRENDA ANN LARA, license number 562829, to practice professional nursing in the state of Texas, be and the same is hereby GRANTED SUBJECT TO THE FOLLOWING CONDITIONS SO LONG AS THE PETITIONER complies 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 §211.01 et. seq. and the stipulations contained in this Order:

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Petitioner's multistate licensure privilege, if any, to practice professional nursing in the State of Texas

IT IS FURTHER AGREED and ORDERED that while Petitioner's license is encumbered by this Order, Petitioner may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Petitioner wishes to work.

(1) PETITIONER SHALL NOT seek employment or practice nursing for compensation until she has completed the following pre-licensure conditions and obtained a license to practice professional nursing from the Board.

(2) PETITIONER SHALL apply for a "Six-Month Clinical Permit" for the limited purpose of completing a refresher course. PETITIONER SHALL NOT, in any way, attempt to use this clinical permit for any purpose other than attending this course.

(3) PETITIONER SHALL successfully complete a nursing refresher course prior to returning to the practice of professional nursing in the State of Texas. PETITIONER SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. The course content shall include: 1) the role of the professional nurse; 2) a review of the nursing process to include assessment, planning, implementation and evaluation; 3) Pharmacology review; 4) medication administration review for all standard route of administration; 5) documentation, quality assurance and legal implications for nursing practice; and 6) current CPR certification. This course must contain a minimum 24-hour clinical component, providing direct patient care, which is to be supervised by another registered nurse.

(4) Upon completion of the refresher course, PETITIONER SHALL return the clinical permit to the office of the Board, and PETITIONER SHALL CAUSE the sponsoring institution to notify the Board, on a form provided by the Board, of Petitioner's successful completion of the refresher course, including the required clinical component.

(5) Upon verification of successful completion of the agreed pre-licensure conditions of reinstatement, as set out in this Order, PETITIONER SHALL pay all re-registration fees and be issued a license to practice professional nursing in the State of Texas, which shall bear the appropriate notation. Said license issued to BRENDA ANN LARA, shall be subject to the following agreed post-licensure stipulations:

(6) PETITIONER SHALL, within one (1) year of relicensure, successfully complete a course in nursing jurisprudence. PETITIONER SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience must include registered nurses. It must be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. Courses focusing on malpractice issues will not be accepted. PETITIONER SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify PETITIONER's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses can be found on the Board's website www.bne.state.tx.us (under BNE events).*

(7) PETITIONER SHALL, within one (1) year of relicensure, successfully complete a course in medication administration. PETITIONER SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. 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. PETITIONER SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify PETITIONER's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(8) PETITIONER SHALL, within one (1) year of relicensure, successfully complete a course in physical assessment. PETITIONER SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. To be approved, the course shall cover all systems of the body. 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.

PETITIONER SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify PETITIONER's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(9) PETITIONER SHALL, within one (1) year of relicensure, successfully complete a course in nursing documentation. PETITIONER SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. PETITIONER SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify PETITIONER's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

IT IS FURTHER AGREED, SHOULD PETITIONER PRACTICE AS A REGISTERED NURSE IN THE STATE OF TEXAS, PETITIONER WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT.

THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(10) PETITIONER SHALL notify all future employers in professional nursing of this Order of the Board and the stipulations on PETITIONER's license. PETITIONER SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(11) PETITIONER SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the PETITIONER by the Board, to the Board's office within five (5) days of employment as a professional nurse.

(12) For the first year of employment as a Registered Nurse under this Order, PETITIONER SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as PETITIONER and immediately available to provide assistance and intervention. PETITIONER SHALL work only on regularly assigned, identified and predetermined unit(s). The PETITIONER SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. PETITIONER SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(13) For the remainder of the stipulation period, PETITIONER SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as PETITIONER, 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 PETITIONER is currently working. PETITIONER SHALL work only regularly assigned, identified and predetermined unit(s). PETITIONER SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. PETITIONER SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(14) PETITIONER SHALL CAUSE each employer to submit, on forms provided to the PETITIONER by the Board, periodic reports as to PETITIONER's capability to practice professional nursing. These reports shall be completed by the Registered Nurse who supervises the PETITIONER. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) months for two (2) years of employment as a professional nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, PETITIONER SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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PETITIONER'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Reinstatement Agreed Order. I certify that my past behavior, except as disclosed in my Petition for Reinstatement of Licensure, has been in conformity with the Board's professional character rule. I have provided the Board with complete and accurate documentation of my past behavior in violation of the penal law of any jurisdiction which was disposed of through any procedure short of convictions, such as: conditional discharge, deferred adjudication or dismissal. I have no criminal prosecution pending in any jurisdiction.

I have reviewed this Order. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I agree to inform the Board of any other fact or event that could constitute a ground for denial of licensure prior to reinstating my license to practice professional nursing in the state of Texas. I understand that if I fail to comply with all terms and conditions of this Order, my license to practice professional nursing in the State of Texas will be revoked, as a consequence of my noncompliance.

Signed this 16 day of May, 2005.

Brenda Lara

BRENDA ANN LARA, Petitioner

Sworn to and subscribed before me this 16th day of May, 2005.

SEAL

Notary Public in and for the State of New Mexico

Approved as to form and substance.

CHRISTOPHER MALISH, Attorney for Petitioner

Signed this 24 day of May, 2005.

WHEREFORE, PREMISES CONSIDERED, the Board of Nurse Examiners for the State of Texas does hereby ratify and adopt the Reinstatement Agreed Order that was signed on the 16th day of May, 2005, by BRENDA ANN LARA, license number 562829, and said Order is final.

Effective this 21st day of July, 2005.

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

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS
****

In the Matter of License Number 562829	§	AGREED
issued to BRENDA ANN LARA	§	ORDER

On this day, the Board of Nurse Examiners for the State of Texas, hereinafter referred to as the Board, accepted the voluntary surrender of License Number 562829, issued to BRENDA ANN LARA, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c) of the Texas Occupations Code.

Respondent waived representation by counsel, informal conference and hearing, and agreed to the entry of this Order.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

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

2. Respondent waived representation by counsel, 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 Diploma in Nursing from Methodist Hospital, Lubbock, Texas, in May 1990. Respondent was licensed to practice professional nursing in the State of Texas in August 1990.

5. Respondent's professional employment history includes:

8/90 to 10/91	Staff Nurse	Methodist Hospital Lubbock, Texas
10/91 to 9/92	Home Health Case Manager	Visiting Nurses Lubbock, Texas
8/92 to 1/93	RN/ Home Health	Kimberly Quality Care Lubbock, Texas
1/93 to 1/93	RN/ Home Health	Calvert Home Health Lubbock, Texas
1/93 to 5/95	Case Manager/Home Health	Great Plains Health Services Lubbock, Texas
6/95 to 10/95	RN/ Home Health	Health Care Unlimited McAllen, Texas
11/95 to 11/96	Quality Assurance Nurse Office Manager	MedCare Home Health Edinburg, Texas
12/96 to 1/97	Unknown	
2/97 to 3/98	RN/ Home Health	Healing Hands Home Health San Antonio, Texas
3/98 to 2/99	Staff Nurse/telephonic triage	United Health Care San Antonio, Texas
3/99 - 9/99	Unknown	
10/99 - 2/00	Surveyor	University of Montana Missoula, Montana
2/00 - 1/01	Charge Nurse	Mineral Community Hospital Superior, Montana
1/01 - 11/01	ER Staff Nurse	Edinburg Regional Hospital Edinburg, Texas
12/01 - 3/02	Staff Nurse	Integrated Health Services Lubbock, Texas
3/02 - present	Unknown	

6. On July 12, 1994, Respondent was issued an Agreed Order of one (1) year of Stipulations by the Board of Nurse Examiners for the State of Texas. A copy of the July 12, 1994, Agreed Order, Findings of Facts, and Conclusions of Law, are attached and incorporated, by reference, as part of this Order.

7. On December 8, 1998, Respondent was issued a Suspend/Probate Agreed Order by the Board of Nurse Examiners for the State of Texas. A copy of the December 8, 1998, Agreed Order, Findings of Fact, and Conclusions of Law, is attached and incorporated, by reference, as part of this Order.

8. At the time of the initial incident, Respondent was employed as a Staff Nurse in the Emergency Room with Edinburg Regional Hospital, Edinburg, Texas, and had been in this position for six (6) months.

9. On or about July 6, 2001, while employed at Edinburg Regional Medical Center, Edinburg, Texas, Respondent failed to assess the neurological status of Patient #313955, Patient #301317, Patient #313856 and Patient #313857, who were admitted to the Emergency Room following a motor vehicle accident. Respondent's conduct deprived subsequent caregivers of vital information on which to base their medical care or institute timely medical interventions.

10. On or about August 27, 2001, while employed at Edinburg Regional Medical Center, Edinburg, Texas, Respondent failed to take vital signs of Patient # 315951, while the patient underwent conscious sedation. Respondent's conduct deprived subsequent caregivers of vital information on which to base their medical care or to institute timely medical interventions.

11. On or about August 27, 2001, while employed at Edinburg Regional Medical Center, Edinburg, Texas, Respondent failed to obtain consent for conscious sedation from Patient # 315951. Respondent's conduct deprived the patient of full disclosure of the specific risks and hazards involved with the procedure.

12. On or about October 8, 2001, while employed at Edinburg Regional Medical Center, Edinburg, Texas, Respondent failed to document the site of an injection of 0.5 mg of Tetanus and 1 gm of Rocephin administered to Patient #317748. In addition, Respondent failed to document the patient's response to the medications. Respondent's conduct deprived subsequent caregivers of vital information on which to base their medical care.

13. On or about November 9, 2001, while employed at Edinburg Regional Medical Center, Edinburg, Texas, Respondent failed to document that a two (2) year old patient, who was admitted to the Emergency Room following an unrestrained motor vehicle accident, had a 3½ cm scalp laceration and contusions over the right mastoid and occipital area. Respondent's conduct deprived subsequent caregivers of essential and vital information required to institute timely medical interventions.

14. Charges were filed on September 19, 2002 and mailed to Respondent on September 22, 2003.

15. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license to practice professional nursing in the State of Texas.

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 violations of Section 301.452(b)(10) & (13), Texas Occupations Code, 22 TEX. ADMIN. CODE §217.11 (7), and 22 TEX. ADMIN. CODE §217.12(2) and (4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against License Number 562829, heretofore issued to BRENDA ANN LARA, including revocation of Respondent's professional license to practice nursing in the State of Texas.

5. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

6. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.

7. Any subsequent reinstatement of this license will be controlled by Section 301.452(b), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of License Number 562829, heretofore issued to BRENDA ANN LARA, to practice professional nursing in the State of Texas, is accepted by the Board of Nurse Examiners. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL immediately deliver the wallet-size license, heretofore issued to BRENDA ANN LARA, to the office of the Board of Nurse Examiners.

2. RESPONDENT SHALL NOT practice professional nursing, use the title "registered nurse" or the abbreviation "RN" or wear any insignia identifying herself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

3. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order;

4. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, if any, to practice professional nursing in the State of Texas.

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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 violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 25th day of Sept, 2003.

Brenda Lara
BRENDA ANN LARA, Respondent

Brenda Ann Lara

Sworn to and subscribed before me this 25th day of Sept, 2003

SEAL

Carmen R. Vige'
Notary Public in and for the State of Texas

CARMEN R. VIGE'
Notary Public, State of Texas
My Commission Expires
05-11-2006

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Board of Nurse Examiners for the State of Texas does hereby accept the voluntary surrender of License Number 562829, previously issued to BRENDA ANN LARA.

Effective this 26th day of September, 2003.

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

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS
****

In the Matter of Permanent Certificate Number 562829 issued to BRENDA ANN LARA	§ § §	AGREED ORDER

An investigation by the Board produced evidence indicating that Brenda Ann Lara, hereinafter referred to as Respondent, may have violated Article 4525(b)(9) & (12), Revised Civil Statutes of Texas, as amended.

An informal conference was held on February 18, 1997, at the office of the Board of Nurse Examiners, in accordance with Article 4524C, Revised Civil Statutes of Texas, as amended.

Respondent appeared in person. Respondent was represented by Susan Henricks, Attorney at Law. In attendance were Penny Puryear Burt, RN, J.D., Of Counsel; Anthony L. Diggs, Director of Investigations; Karen Burk, RN, Investigator; and Noemi Leal, Senior Investigator.

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.

2. Respondent waived notice and hearing, and consented to the entry of this order.

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

4. Respondent graduated from a Diploma Nursing Program from Methodist Hospital, Lubbock, Texas in May 1990.

5. Respondent's professional employment history includes:

August 1990 to October 1991	Staff Nurse Methodist Hospital Lubbock, Texas
October 1991 to August 1992	Home Health Case Manager Visiting Nurses Lubbock, Texas
August 1992 to January 1993	RN/ Home Health Kimberly Quality Care Lubbock, Texas
January 1993 to January 1993	RN/ Home Health Calvert Home Health Lubbock, Texas
January 1993 to May 1995	Case Manager/Home Health Great Plains Health Services Lubbock, Texas
June 1995 to October 1995	RN/ Home Health Health Care Unlimited McAllen, Texas
November 1995 to November 1996	Quality Assurance Nurse/Office Manager MedCare Home Health Edinburg, Texas
February 1997 to March 1998	RN/ Home Health Healing Hands Home Health San Antonio, Texas
March 1998 to Present	Staff Nurse/ telephonic triage United Health Care San Antonio, Texas

6. Respondent's license to practice professional nursing was placed on stipulations for one (1) year by the Board of Nurse Examiners on July 12, 1994. A copy of the Order is attached and incorporated by reference as part of this order.

7. At the time of the incidents, Respondent was employed as a Case Manager with Great Plains Health Services, Lubbock, Texas and was in this position from January 1993 to May 1995.

8. Respondent, while employed with the aforementioned facility, failed to document the administration of insulin in the patients' medical records, i.e.;

DATE	PATIENT	PHYSICIAN'S ORDER
10/22/94	0005	Humulin N, 15u, q. a.m. S.Q.
10/23/94	0005	Humulin N, 15u, q. a.m. S.Q.
10/24/94	0005	Humulin N, 15u, q. a.m. S.Q.
10/26/94	0005	Humulin N, 15u, q. a.m. S.Q.
10/27/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/01/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/05/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/17/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/19/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/26/94	0005	Humulin N, 15u, q. a.m. S.Q.
01/27/94	0005	Humulin N, 15u, q. a.m. S.Q.
11/28/94	0005	Humulin N, 15u, q. a.m. S.Q.
12/05/94	0005	Humulin N, 15u, q. a.m. S.Q.
12/09/94	0005	Humulin N, 15u, q. a.m. S.Q.
12/12/94	0005	Humulin N, 15u, q. a.m. S.Q.
12/14/94	0005	Humulin N, 15u, q. a.m. S.Q.

Respondent's conduct was likely to injure patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in patient developing hypoglycemia.

9. Respondent, while employed with Great Plains Health Services, Lubbock, Texas, failed to report to the physician the elevated blood sugar level of patient number 0003. The physician's order required reporting blood sugar levels lower than 100 or greater than 150. Respondent failed to report the following:

DATE	BLOOD SUGAR LEVEL
03/21/95	212 mg/dl
03/22/95	156 mg/dl
03/24/95	162 mg/dl
03/27/95	162 mg/dl
04/07/95	198 mg/dl
04/08/95	166 mg/dl
04/09/95	158 mg/dl
04/12/95	162 mg/dl
04/14/95	197 mg/dl
04/19/95	174 mg/dl
04/20/95	160 mg/dl
04/28/95	161 mg/dl

Respondent's conduct exposed the patient unnecessarily to a risk of harm in that failure to report the blood sugar levels to the physician may have prevented the physician from evaluating the efficaciousness of the treatment regimen.

10. Respondent, while employed with the aforementioned facility, failed to perform a venipuncture for complete blood count, as ordered by the physician for the months of July 1994, September 1994, November 1994, December 1994 and February 1995 for patient number 0001. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that failure to obtain the ordered diagnostic test may have prevented the physician from evaluating the efficaciousness of the treatment regimen.

11. Respondent, while employed with the aforementioned facility, on or about September 1, 1994, failed to document a physician's order for Tylenol in the medical record for patient number 0001. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that subsequent care givers would rely on the documented orders to medicate the patient.

12. Respondent, while employed with the aforementioned facility, failed to administer B-12 injections to patient number 0001 as ordered by the physician for the months of March, July, September, October and November 1994. Respondent's conduct exposed the patient unnecessarily to a risk of harm in that failure to administer the ordered B-12 injections to the patient as ordered could have resulted in the recurrence of the condition for which the patient was being treated.

13. Respondent, while employed with the aforementioned facility, administered an incorrect dose of insulin and prefilled syringes with incorrect doses of insulin for the following patients:

Date	Patient	Physician's Order	Dose Given/Prefilled
04/19/94	0002	Humulin N 50u a.m.	Prefilled 3 syringes with Humulin N 40u am
04/26/94	0002	Humulin N 50u a.m.	Prefilled 7 syringes with Humulin N 40u am
11/22/94	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled 7 syringes with 35 units a.m.
12/26/94	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled 7 syringes with 35 units a.m.
01/03/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled 7 syringes with 35 units a.m.
01/17/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled 7 syringes with 35 units a.m.
01/24/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled 7 syringes with 35u
01/30/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled syringes with 35u
02/14/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled syringes with 30u
02/21/95	0005	Humulin N, 15u, q a.m. S.Q.	Prefilled syringes with 35u
04/13/95	0004	Humulin 30u a.m.	Administered 38 units a.m.
04/15/95	0004	Humulin 30u a.m.	Administered 38 units a.m.
04/16/95	0004	Humulin 30u a.m.	Administered 38 units a.m.

Respondent's conduct exposed the patient unnecessarily to a risk of harm in that failure to administer or prefill syringes with the correct amount of insulin could result in failure to maintain the patient's blood sugar control.

14. Respondent, while employed with the aforementioned facility, prefilled syringes with insulin for patients without a physician's order, as follows:

DATE	PATIENT	NUMBER OF SYRINGES PREFILLED
4/10/94	0002	Prefilled 2 syringes
4/12/94	0002	Prefilled 2 syringes
4/26/94	0002	Prefilled 7 syringes with 40 units a.m. and prefilled 7 syringes with 30 units p.m.
11/3/94	0005	Prefilled syringes with 15 units

Respondent's conduct exposed the patient unnecessarily to a risk of harm in that prefilling syringes without a physician's order may result in the patient self administering an incorrect amount of insulin.

15. Respondent provided evidence that the foregoing incidents occurred during a period of extreme mental anguish and distress due to her involvement in a sharply contested divorce and custody dispute with her former husband. Respondent admits that she failed to completely and accurately documents all treatments, medication administration and other nursing interventions she performed.

CONCLUSIONS OF LAW

1. Pursuant to Article 4525, Revised Civil Statutes of Texas, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Article 4525(b)(9) & (12), TEX. REV. CIV. STAT. ANN., and 22 TEX.ADMIN.CODE §217.11 (6), (7) & (12), and 22 TEX. ADMIN. CODE §217.13(3), (4) & (5).

4. The evidence received is sufficient cause pursuant to Article 4525(b), TEX. REV. CIV. STAT. ANN., to take disciplinary action against license number 562829, heretofore issued to BRENDA ANN LARA.

AGREED SANCTIONS

IT IS THEREFORE AGREED, subject to ratification by the Board of Nurse Examiners, that License Number 562829, previously issued to BRENDA ANN LARA, to practice professional nursing in Texas is hereby SUSPENDED, the suspension is stayed and Respondent is placed on probation for two (2) years. RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Art. 4513 et. seq., the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 et. seq. and this order.

IT IS FURTHER AGREED the license issued to BRENDA ANN LARA, shall be subject to the following probation conditions for two (2) years of employment as a professional nurse:

(1) RESPONDENT SHALL deliver the wallet-size license issued to , to the office of the Board of Nurse Examiners within ten (10) days of the date of this order for appropriate notation.

(2) RESPONDENT SHALL, within one (1) year of entry of this order, successfully complete a course in Nursing Jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home Study courses and video programs will not be approved. In order for the course to be approved, the target audience must include registered nurses. It must be a minimum of six (6) contact hours in length. The course's content should include the Nursing Practice Act, Standards of Practice, and documentation of care. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure.

(3) Upon securing employment in a hospital setting, RESPONDENT SHALL successfully complete an orientation supervised by a registered nurse. The orientation shall include instruction in documentation, medication administration, nursing process to include assessment, planning, implementation and evaluation. RESPONDENT SHALL CAUSE the supervising registered nurse to submit to the Board written notification of Respondent's successful completion of the orientation.

(4) RESPONDENT SHALL notify each present employer in professional nursing of this order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a copy of this order to each present employer within five (5) days of notification of this order. RESPONDENT SHALL notify all potential employers in professional nursing of this order of the Board and the stipulations RESPONDENT's license. RESPONDENT SHALL present a copy of this order to each potential employer prior to employment.

(5) RESPONDENT SHALL CAUSE each present employer in professional nursing to submit the Notification of Employment form to the Board's office within ten (10) days of notification of this order. RESPONDENT SHALL CAUSE each potential employer to submit the Notification of Employment form to the Board's office within five (5) days of employment as a professional nurse.

(6) For the first year of employment as a Registered Nurse, RESPONDENT SHALL be directly supervised by a registered nurse, who will act as Respondent's preceptor. Direct supervision requires the preceptor to be working on the same unit as RESPONDENT and readily available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by

a nurse registry, temporary nurse employment agency or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) For the remainder of the probation period, RESPONDENT SHALL be supervised by a registered nurse who is on the premises. The supervising RN 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. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency or home health agency. RESPONDENT SHALL NOT be self employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided by the Board, periodic reports as to RESPONDENT's capability to practice professional nursing. These reports shall be completed by the registered nurse who supervises the RESPONDENT. These reports shall be submitted to the office of the Board at the end of each three (3) months for two (2) years of employment as a professional nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this order, RESPONDENT SHALL be issued an unencumbered license to practice professional nursing in the State of Texas.

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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 violations alleged. By my signature on this order, I agree to the Findings of Fact, Conclusions of Law, Agreed Sanctions, and any stipulation of this order to avoid further disciplinary action in this matter. I consent to the issuance of the Agreed Sanctions. I waive judicial review of this order. I understand that this order is subject to ratification by the Board. When the order is ratified, the terms of this order become effective, and a copy will be mailed to me.

Signed this 24 day of October, 1998.

Brenda Ann Lara

BRENDA ANN LARA, Respondent

Sworn to and subscribed before me this 24th day of October, 1998.

SEAL

Notary Public in and for the State of Texas

Approved as to form and substance.

Susan Henricks, Attorney for Respondent

Signed this 27th day of October, 1998.

562829:003

WHEREFORE, PREMISES CONSIDERED, the Board of Nurse Examiners for the State of Texas does hereby ratify and adopt the Agreed Order that was signed on the 24th day of October, 1998, by BRENDA ANN LARA, license number 562829, and said order is final.

Effective this 8th day of December, 1998.

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

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

In the Matter of Permanent Certificate Number 562829 issued to BRENDA ANN HARRISON	§ § §	AGREED ORDER

An investigation by the Board produced evidence indicating that BRENDA ANN HARRISON, hereinafter referred to as Respondent, may have violated Article 4525(b)(9), Revised Civil Statutes of Texas as amended.

An informal hearing was held on May 17, 1994, at the office of the Board of Nurse Examiners, in accordance with Article 4524C, Revised Civil Statutes of Texas, as amended.

Respondent appeared in person. In attendance were Cady Crismon M.S.N., R.N., C.N.S., Director of Practice and Compliance; Roy Rawls, Assistant General Counsel; and Cynthia McRae, Investigator.

FINDINGS OF FACTS

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

2) Respondent graduated from a Diploma Program at Methodist Hospital, Lubbock, Texas. She became licensed as a Registered Nurse in the State of Texas in August, 1990.

3) Respondent was employed as a Staff Nurse in a hospital setting from approximately August, 1990 to August, 1991.

4) Respondent began employment as a PRN home health nurse for Visiting Nurses Association in Lubbock from Approximately August, 1991 to August, 1992.

5) Respondent began employment as a PRN home health nurse for Kimberly Quality Care, Lubbock, Texas in approximately August, 1992.

6) On or about December 24, 1992 and December 25, 1992, while employed at Kimberly Quality Care, Lubbock, Texas. Respondent falsely documented home-health visits that she did not make in the Nursing Notes of patient WC which included an assessment. Respondent was terminated from Kimberly Quality Care on January 12, 1993.

7) Respondent is currently employed as PRN staff nurse for University Medical Center, Lubbock, Texas and PRN home health nurse for Great Plains Home Health, Lubbock, Texas.

CONCLUSIONS OF LAW

1. That pursuant to Article 4525, Revised Civil Statutes of Texas, as amended the Board has jurisdiction over this matter.

2. That the evidence received was sufficient to prove violation(s) of Article 4525(b)(9), TEX. REV. CIV. STAT. ANN., and 22 TEX. ADMIN. CODE §217.13(5).

3. That the activities of the Respondent constituted sufficient cause pursuant to Article 4525(b), TEX. REV. CIV. STAT. ANN., to take disciplinary action against license number 562829, heretofore issued to BRENDA ANN HARRISON.

AGREED TERMS, STIPULATIONS AND CONDITIONS

IT IS THEREFORE AGREED, subject to ratification by the Board of Nurse Examiners, that Respondent receive the discipline of stipulations to practice as follows for one (1) year:

(1) Respondent shall comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, art. 4513 et. seq., the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 et. seq. and the Terms, Stipulations and Conditions of this Order.

(2) IT IS FURTHER AGREED that the wallet-size license issued to BRENDA ANN HARRISON, be delivered to the office of the Board of Nurse Examiners within ten (10) days of the date of this Order for appropriate notation.

(3) RESPONDENT shall notify each present employer in professional nursing of this Order of the Board and the stipulations/probation conditions on RESPONDENT's license. RESPONDENT shall present a copy of this Order to each present employer within five (5) days of notification of this Order. RESPONDENT shall notify all potential employers in professional nursing of this Order of the Board and the stipulations/probation conditions on RESPONDENT's license. RESPONDENT shall present a copy of this Order to each potential employer prior to employment.

(4) RESPONDENT shall, within one (1) year of entry of this Order, successfully complete a course in Nursing Jurisprudence. RESPONDENT shall obtain Board approval of course prior to enrollment. Home Study courses will not be approved. RESPONDENT shall cause the sponsoring institution to submit a Verification of Completion form to verify RESPONDENT's successful completion of the course.

RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the truth of the matters previously set out. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Terms, Stipulations and Conditions to avoid further disciplinary action in this matter; and, I consent to the issuance of this discipline. I waive my right to a hearing and judicial review of this Order. I understand that this Order is subject to ratification by the Board and becomes effective when signed by the Executive Director of the Board.

Dated this 2nd day of June, 1994.

Brenda Ann Harrison

BRENDA ANN HARRISON

Sworn to and subscribed before me this 2nd day of June, 1994.

IRMA HUSTON
Notary Public, State of Texas
My Commission Expires 10-16-94

Irma Huston

Notary Public in and for the State of Texas

Approved as to form and substance.

David Martinez, Attorney for Respondent

Dated this 2nd day of June, 1994.

WHEREFORE, PREMISES CONSIDERED, the Board of Nurse Examiners for the State of Texas does hereby ratify and adopt the Agreed Order signed by BRENDA ANN HARRISON, license number 562829, on the 2nd day of June, 1994, and said Order is final.

Signed this 12 day of July, 1994.

Louise Waddill, Ph.D., R.N.
Executive Director on behalf
of said Board