DOCKET NUMBER 507-22-2016

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 735461,	**§**	**OF**
ISSUED TO	**§**	
SAFARAHH MCMILLAN	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: SAFARAHH MCMILLAN
C/O LANE M. BIRKENFELD, ATTORNEY
FIELD, MANNING, STONE, HAWTHORNE & AYCOCK, P.C.
2112 INDIANA AVENUE
LUBBOCK, TX 79410

BRENT MCCABE
ADMINISTRATIVE LAW JUDGE
PO BOX 13025
AUSTIN, TX 78711-3025

At the regularly scheduled public meeting on January 19, 2023, 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 generally warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10), (12) & (13)(effective through 8/31/21).[1] A Warning or Reprimand with Stipulations is authorized for a second tier, sanction level I sanction for a violation of §301.452(b)(10), (12) & (13)(effective through 8/31/21). Based on the findings of the ALJ, the Board agrees with the ALJ that a Warning with Stipulations is the most appropriate sanction in this matter.[2]

The evidence establishes that the Respondent was impaired during her shift, which led to her lacking in fitness and failing to properly record the vital signs of her patients and the medications she administered at the end of her shift.[3] The Respondent's conduct carried a risk of harm to vulnerable laboring women and their unborn babies.[4] Further, there is evidence that Respondent's seizure disorder is a serious diagnosis, resulting in periods of confusion and disorientation.[5]

The ALJ found mitigating factors applied as well. First, the ALJ found that the actual harm and severity of the conduct are not aggravating factors in this case.[6] The ALJ also found that the number of events is not significantly aggravating since the Respondent's impairment occurred during the last few hours of her shift.[7] The ALJ also found the system dynamics on the unit contributed to the problem.[8] Further, the evidence did not establish that Respondent was impaired by alcohol, illegal drugs, or controlled substances or prescription medications, or that any of these were involved in this case.[9] There is also no direct evidence that Respondent abused or diverted any medication.[10] Further, Respondent has shown a willingness to self-report and be open with her condition and status.[11]

Additionally, Dr. Dees's evaluation of Respondent was overall positive. Although the Respondent's neurological areas of weakness raised concern over her ability to focus, pay attention, or multi-task, as well as her processing speed,[12] Dr. Dee's evaluation indicated a low probability of substance use disorder, and Dr. Dees found the Respondent fit to practice, with the implementation of certain stipulations to address her neurological deficiencies.[13]

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

---

[1] See page 28 of the PFD.
[2] See page 36 of the PFD.
[3] See page 26 of the PFD.
[4] See page 29 of the PFD.
[5] See page 33 of the PFD.
[6] See page 29 of the PFD.
[7] See page 30 of the PFD.
[8] See page 32 of the PFD.
[9] See page 31 of the PFD.
[10] See *id.*
[11] See page 33 of the PFD.
[12] See pages 17-18 of the PFD.
[13] See page 33 of the PFD.

Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(3), that a Warning with Stipulations is the most appropriate sanction in this case.

The Board agrees with the ALJ that the sanction in this matter should be crafted to address the concerns demonstrated by the Respondent's ability to (1) work in high-stress, critical-care areas; (2) manage her seizure disorder, symptoms, and triggers; and (3) identify periods of impairment caused by her disorder and treatment.[14] As such, the Board agrees with the ALJ's recommended stipulations, which are also consistent with recommendations made by Dr. Dees and are within his area of expertise and rooted in his clinical findings.[15]

First, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a documentation course, a professional accountability course, and a critical thinking course.[16] The Board also agrees with the ALJ that the Respondent's nursing practice should be supervised during the one year stipulation period. The Board finds that one year of indirect supervision should sufficiently ensure the Respondent's safe practice. However, the Board also agrees with the ALJ that the Respondent should not accept assignments in critical care settings or float, on-call, overtime, or night shifts.[17] The Board also finds that the Respondent should be required to inform her employers of this Order and to submit quarterly employer reports to the Board so the Board can monitor the Respondent's progress and completion of the Order. These supervisory stipulations are intended to monitor the Respondent's continued fitness to practice and to prevent future violations from occurring by ensuring that any deficiencies in the Respondent's practice will be discovered quickly and remediated appropriately. Given the assessment of the Respondent's mild neurocognitive disorder, the Board further agrees with Dr. Dees and the ALJ's recommendations regarding consultation with a neurologist and sleep specialist, attending counseling, and having a plan of action for when the Respondent feels overwhelmed.[18] These stipulations will be helpful to the Respondent as she moves forward in managing her diagnoses and working in a nursing role and will help guard against risk to patients. These stipulations are also consistent with 22 Tex. Admin. Code §213.33(e)(3)[19].

---

[14] See page 35 of the PFD.

[15] See page 34 of the PFD.

[16] 22 Tex. Admin. Code §213.33(f) requires every order issued by the Board to include participation in a program of education, which at a minimum, shall include a review course in nursing jurisprudence and ethics. Section 213.33(e)(10) authorizes participation in remedial education courses designed to address competency deficiencies, such as those identified by the ALJ in this case.

[17] See page 36 of the PFD.

[18] See *id.*

[19] 22 Tex. Admin. Code §213.33(e)(3), which authorizes reasonable stipulations that may include remedial education courses and practice for at least one year under the direction of a nurse designated by the Board; limitations on nursing activities/practice settings; and submitting to care, supervision, counsling, or treatment by a health provider designated by the Board.

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

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

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

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

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

I. COMPLIANCE WITH LAW

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

II. UNDERSTANDING BOARD ORDERS

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

III. REMEDIAL EDUCATION COURSE(S)

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

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content

shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.

B. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

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

D. **The course "Professional Accountability ...,"** a 5.4 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

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

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

Further, at the time RESPONDENT delivers the Order to an employer, RESPONDENT must speak to the employer about her seizure disorder and the symptoms she may experience from it, as well as developing written guidelines or procedures for the management of her seizure disorder, which, at a minimum, should contain a process by which RESPONDENT may self report symptoms or seizures, how RESPONDENT and other staff should handle a seizure or potential effects of a seizure during the shift, the process by which RESPONDENT should be removed from duty including when a drug test should be performed, and when such a process should be triggered.

C. **Indirect Supervision:** For the duration of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited. Further, RESPONDENT SHALL NOT practice as a nurse in any critical care area. Critical care areas include, but are not limited to, intensive care units, emergency rooms, operating

rooms, telemetry units, recovery rooms, and labor and delivery units. RESPONDENT SHALL NOT practice as a nurse on the night shift, work overtime, accept on-call assignments, or be used for coverage on any unit other than the identified, predetermined unit(s) to which Respondent is regularly assigned.

D. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for four (4) quarters [one (1) year] of employment as a nurse.

V. REPORTS

While working as a nurse under the terms of this Order, RESPONDENT SHALL participate in therapy with a professional counselor with credentials approved by the Board. RESPONDENT SHALL CAUSE the therapist to submit written reports, on forms provided by the Board, as to the RESPONDENT'S progress in therapy, rehabilitation and capability to safely practice nursing. The report must indicate whether or not the RESPONDENT'S stability is sufficient to provide direct patient care safely. For the first three (3) month quarterly period RESPONDENT works as a nurse under the terms of this Order, reports are to be submitted to the Board each and every month. If therapy is recommended by the therapist for an additional period of time, the reports shall then be submitted to the Board at the end of each three (3) month quarterly period in which the RESPONDENT is working as a nurse under the terms of this Order, for the remainder of the term of the Order, or until RESPONDENT is dismissed from therapy, whichever is earlier.

While working as a nurse under the terms of this Order, RESPONDENT SHALL consult with a neurologist approved by the Board regarding the RESPONDENT's seizure activity, as well as the cognitive rehabilitation to address cognitive deficits identified by Dr. Dees. RESPONDENT SHALL CAUSE the neurologist to submit written reports, on forms provided by the Board, as to the RESPONDENT'S progress and capability to safely practice nursing. The report must indicate whether or not the RESPONDENT'S stability is sufficient to provide direct patient care safely. Such reports are to be furnished each and every month for three (3) months. If treatment is recommended beyond the initial three (3) months, the reports shall then be required at the end of each three (3) month quarterly period for the remainder of the stipulation period, or until RESPONDENT is dismissed from treatment.

While working as a nurse under the terms of this Order, RESPONDENT SHALL consult with a sleep specialist approved by the Board to reduce RESPONDENT'S problematic sleep habits or inability to sleep. RESPONDENT SHALL CAUSE the

sleep specialist to submit written reports, on forms provided by the Board, as to the RESPONDENT'S progress and capability to safely practice nursing. The report must indicate whether or not the RESPONDENT'S stability is sufficient to provide direct patient care safely. Such reports are to be furnished each and every month for three (3) months. If treatment is recommended beyond the initial three (3) months, the reports shall then be required at the end of each three (3) month quarterly period for the remainder of the stipulation period, or until RESPONDENT is dismissed from treatment.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

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

Entered this 19th day of January, 2023.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; 507-22-2016 (September 12, 2022)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

September 12, 2022

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

VIA E-FILE TEXAS

Re: SOAH Docket No. 507-22-2016; Texas Board of Nursing v. Safarahh McMillan

Dear Ms. Thomas:

Please find attached a Proposal for Decision in this case. It contains my recommendation and underlying rationale. Exceptions and replies may be filed by any party in accordance with 1 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,

Brent McCabe,
Presiding Administrative Law Judge

Attachment

CC: JoAnna Starr, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, Texas 78701 - **VIA E-FILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) - **VIA E-FILE TEXAS and INTERAGENCY MAIL**
Safarahh McMillan, 1714 Tuscorora Ct., San Angelo, Texas 76904 - **VIA E-FILE TEXAS**

SOAH Docket No. 507-22-2016 Suffix: TBN

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
SAFARAHH MCMILLAN, RN # 735461,
RESPONDENT

TABLE OF CONTENTS

SOAH Docket No. 507-22-2016 Suffix: TBN

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
SAFARAHH MCMILLAN, RN # 735461,
RESPONDENT

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) alleges that, on January 18, 2021, Safarahh McMillan (Respondent), a licensed registered nurse (RN), failed to appropriately document medical data for two patients and lacked fitness to practice nursing by exhibiting signs of impaired behavior while on duty. Staff seeks a three-year probated suspension with stipulations. The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the violations but that the nature of the conduct proven warrants a lesser penalty and recommends that the Board enter a one-year warning with the stipulations noted below.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

ALJ Brent McCabe of the State Office of Administrative Hearings convened a hearing on the merits via Zoom videoconference on July 11, 2022. Staff was represented by Assistant General Counsel JoAnna Starr. Respondent appeared and represented herself. The record closed July 14, 2022.

There are no contested issues of notice or jurisdiction in this case; therefore, those matters are addressed solely in the findings of fact and conclusions of law.

II. APPLICABLE LAW

Pursuant to the Nursing Practice Act (Act), a nurse is subject to disciplinary action for:

- unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient or the public;
- a lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public; or
- failure to care adequately for a patient to conform to the minimum standards of acceptable nursing practice in a manner that, in the board's opinion, exposes a patient or other person unnecessarily to risk of harm.[1]

The Board defines the minimum standards for the practice of nursing to include:

[1] Tex. Occ. Code § 301.452(b)(10), (12), (13) (2021 ver., since amended). As of September 1, 2021, Texas Occupations Code section 301.452(b)(13) has been renumbered as (b)(14).

- Knowing and conforming to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;

- Implementing measures to promote a safe environment for clients and others;

- Accurately and completely reporting and documenting: (i) the client's status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist, or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s); and (vi) contacts with other health care team members concerning significant events regarding client's status; and

- Accepting only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability. [2]

The Board defines "unprofessional conduct" to include:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board rules;

- Failing to conform to generally accepted nursing standards in applicable practice settings;

- Improper management of client records;

- Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care;

[2] 22 Tex. Admin. Code § 217.11(1)(A), (B), (D), (T).

- Conduct that may endanger a client's life, health, or safety; and
- Inability to Practice Safely—demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness, use of alcohol, drugs, chemicals, or any other mood-altering substances, or because of any mental or physical condition.[3]

The Board must adopt a schedule of disciplinary sanctions to ensure that a sanction is appropriate for the violation.[4] When determining the proper sanction, the Board shall consider: (1) whether the person is being disciplined for multiple violations or has previously been the subject of disciplinary action by the Board and has previously complied with applicable law; (2) the seriousness of the violation; (3) the threat to public safety; and (4) any mitigating factors.[5] When a nurse violates the Act or related rules, the Board is required to impose a disciplinary sanction, which can range from remedial education to license revocation.[6]

The Board's schedule of disciplinary sanctions is a disciplinary matrix.[7] The matrix categorizes violations into tiers and sanction levels based on the seriousness of the offense and risk of harm to patients or the public.[8] There are also factors listed to be considered when determining the appropriate sanction, including the extent to which system dynamics in the practice setting contributed to the

[3] 22 Tex. Admin. Code § 217.12(1)(A)-(C), (E), (4), (5).

[4] Tex. Occ. Code § 301.4531(a).

[5] Tex. Occ. Code § 301.4531(b).

[6] Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

[7] 22 Tex. Admin. Code § 213.33.

[8] 22 Tex. Admin. Code § 213.33(b).

problem.[9] If multiple violations have been committed, the Board should consider the most severe sanction recommended by the matrix.[10]

Staff has the burden of proving its allegations by a preponderance of the evidence, and Respondent has the burden of proving mitigating factors, if any.[11]

III. EVIDENCE

At the hearing, Staff offered 19 exhibits, which were admitted,[12] and offered the testimony of nine witnesses. Two witnesses were experts: (1) Wayne Dees, a neuropsychologist who evaluated Respondent, and (2) Elise McDermott, nursing consultant for the Board. The remaining seven witnesses were nurses and administrators involved in the January 18, 2021 incident in the labor and delivery unit (Unit) at Shannon Women's and Children's Hospital in San Angelo, Texas:

Witness	Description
Karen Dumas	Ms. Dumas was the Unit's manager and was present during Respondent's shift.

[9] 22 Tex. Admin. Code § 213.33(c).

[10] 22 Tex. Admin. Code § 213.33(c).

[11] 1 Tex. Admin. Code § 155.427; *see also Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

[12] *See generally* Staff Ex. 1-4b; 5-10, 14-18, 20-21. Staff Exhibits 1-4b contain the Board's notice and jurisdiction documents. Exhibit 5 is the psychological evaluation performed by Dr. Dees at the Austin Center for Therapy & Assessment. Staff Exhibit 6 consists of department records and policies for the Labor & Delivery Unit at the hospital. Staff Exhibits 7-10, 14, and 20-21 contain medical and pharmacy records from Shannon Women's and Children's Hospital in San Angelo, Texas. Staff Exhibits 15-16 contain personnel and payroll records for Respondent. Staff Exhibit 17 contains witness statements. Exhibit 18 is curriculum vitae of Elise McDermott.

Witness	Description
Pauline Niemann-Tuerk	Ms. Niemann-Tuerk was the nurse anesthetist for the Unit during Respondent's shift.
Sarah Gallander	Ms. Gallander was the charge nurse of the Unit during Respondent's shift.
Brittany Cummings	Ms. Cummings is an RN who worked during Respondent's shift on January 18, 2021.
Shanda Halfmann	Ms. Halfmann is an RN who worked the shift prior to Respondent's shift on January 18, 2021.
Tiffany Halsell	Ms. Halsell is an RN who worked the shift after Respondent's shift on January 18, 2021.
Stacie Elizondo	Ms. Elizondo was the administrative director of Women's and Children's Services at the hospital on January 18, 2021.

Respondent offered her own testimony and did not offer any exhibits.

A. STAFF'S EVIDENCE

1. January 18, 2021

In January 2021, Respondent was a registered nurse working in the labor and delivery unit (Unit) at Shannon Women's and Children's Hospital. On January 18, 2021, Respondent worked a half shift from approximately noon

to 6:00 p.m.[13] When she arrived, she looked put together with her hair and make-up done, and there were no concerns for her fitness at that time.[14] At some point in the afternoon, Respondent left the Unit, with the permission of the charge nurse, to go to the pharmacy and her car.[15] Sometime later, she returned.[16] At approximately 5:00 p.m., several nurses observed that Respondent's appearance and behavior had changed.[17] The nurses reported that Respondent looked drowsy and seemed to be nodding off while sitting at the nurse's station.[18] One nurse described Respondent's appearance as altered with messy hair and smeared makeup.[19] Multiple nurses asked Respondent if she was all right and she responded that she did not sleep well and was tired.[20] Respondent had issues logging into the computer and, at one point, was observed to be holding only one key down for an extended period of time.[21]

Nurse anesthetist Ms. Niemann-Tuerk testified that, in one interaction, she inquired about one of the patients and was unable to understand Respondent's answer.[22] Ms. Halsell testified that Respondent's speech was slurred. Ms. Niemann-Tuerk also witnessed a staff member tell Respondent that the patient

---

[13] Testimony of S. Halfmann, T. Halsell.

[14] Testimony of S. Halfmann, B. Cummings, S. Gallander, P. Niemann-Tuerk. Ms. Dumas noted that Respondent looked normal but tired.

[15] Testimony of S. Gallander.

[16] Testimony of B. Cummings, S. Gallander, P. Niemann-Tuerk.

[17] Testimony of B. Cummings, S. Gallander, P. Niemann-Tuerk.

[18] Testimony of B. Cummings, S. Gallander, P. Niemann-Tuerk, K. Dumas.

[19] Testimony of B. Cummings.

[20] Testimony of B. Cummings.

[21] Testimony of B. Cummings, P. Niemann-Tuerk.

[22] Testimony of P. Niemann-Tuerk. However, Ms. Niemann-Tuerk also noted that Respondent answered appropriately and intelligibly to a staff member who inquired about a patient needing medication.

had asked about her Cytotec medication, which was late. Respondent replied that the patient was supposed to call Respondent when she was done eating.[23] She then went into the medication room.[24] Also, while Ms. Niemann-Tuerk was at the station, Dr. Wilson appeared and asked for Respondent.[25] He indicated that Patient #1 had been ready since 3:00 p.m. to begin active labor, and he had expected Respondent to be with the patient to assist with pushing.[26] Dr. Wilson then went to push with the patient himself.[27] None of the nurses testified that they observed Respondent take any medication or ingest any drug that could impair her functioning.[28]

Save Ms. Dumas, each nurse expressed concern at that time for Respondent's behavior:

- Ms. Cummings testified that she reported the behavior to the Unit manager, Ms. Dumas, and began monitoring Respondent's patients because of concerns that Respondent was not monitoring the patients' fetal heart rates (FHR)—which are important for ensuring fetal wellbeing throughout the labor.

---

[23] Testimony of P. Niemann-Tuerk, K. Dumas.

[24] Testimony of P. Niemann-Tuerk, K. Dumas. Ms. Dumas said, at the time, this was normal to her.

[25] Testimony of P. Niemann-Tuerk, T. Halsell.

[26] Testimony of P. Niemann-Tuerk, T. Halsell. From the medical records, it appears that the testimony is referring to MRN 20668497, the medical record for the patient referred to herein as Patient #1. *See* Staff Ex. 8 at 12. The medical record shows that labor onset was listed at 3:00 p.m. on January 18, 2021, with complete dilation recorded at 4:57 p.m. and pushing started at 5:55 p.m. Staff Ex. 8 at 12. Ms. Gallander testified that a one-hour difference between complete dilation and the start of pushing may be appropriate if it was the patient's first pregnancy like this patient. For this patient, Ms. Gallander also noted that, during delivery, there were postpartum concerns of excessive bleeding. *See* Staff Ex. 8 at 15. Dr. Wilson described the delivery as "uneventful." Staff Ex. 8 at 6.

[27] Testimony of P. Niemann-Tuerk, T. Halsell.

[28] *See* Testimony of B. Cummings, P. Niemann-Tuerk, K. Dumas, S. Gallander. Also, the nurses acknowledged that Respondent had no reason to hide that she was taking her medication, because, as discussed below, her medical condition was known to her colleagues. Testimony of S. Gallander, K. Dumas.

- Ms. Gallander, the charge nurse, felt that Respondent should have been removed from the floor, but, because she was busy in multiple labors that day, she did not report her concerns to Ms. Dumas and did not take any action to remove Respondent from the Unit, restrict her access to patients, or ensure coverage for Respondent's patients.

- Ms. Niemann-Tuerk also believed that Respondent should be removed from duty but did not express her concerns to Ms. Dumas—whom she felt was not adequately addressing the situation. Instead, she contacted Ms. Elizondo to report an impaired nurse on the Unit that needed immediate action.[29] After speaking with Ms. Elizondo, Ms. Niemann-Tuerk used her phone to record Respondent to document her behavior.

- Ms. Dumas, the Unit manager, had no concerns with Respondent's fitness but acknowledged that she did not notice any behaviors other than drowsiness.

After these interactions, Respondent completed her shift at approximately 6:00 p.m. Ms. Halsell testified that, when taking over a patient from Respondent, she observed that the medical records did not indicate that the patient had received her 5:30 p.m. dose of Cytotec—a drug to ripen the cervix and induce contractions—or that the patient had received a dose of Stadol—a narcotic pain reliever. However, when Ms. Halsell spoke to the patient and her family, they indicated that the patient had received both the Cytotec and Stadol doses from Respondent.[30] Furthermore, Ms. Halsell indicated that Respondent had placed a new intravenous (IV) line after the previous line was no longer appropriate, but Respondent did not properly record this new line. Ms. Halsell also noted that there

[29] Ms. Elizondo was not present at the hospital at the time. Having spoken to Ms. Niemann-Tuerk, Ms. Elizondo called Ms. Dumas and asked her to take care of it and arrange a drug test for Respondent through the human resources department.

[30] Ms. Halsell could not recall whether Respondent orally told her that she had administered the Cytotec and Stadol.

was a lack of data recording relating to contractions, cervical exams, and FHR. She testified that she asked Respondent to fix the record to reflect what had been given. Respondent then attempted to login but could not. Ms. Halsell felt someone needed to take Respondent home because she seemed disoriented and drowsy, but Respondent left before she could be stopped. Regarding the Cytotec dose, Ms. Halsell stated that, because of the confusion over whether the 5:30 p.m. dose had been administered, she called the doctor to confirm that she should not give the 5:30 p.m. dose and mark it as not given. Ms. Halsell testified that delaying Cytotec may prolong labor. If it were given (and there was a previous dose), it could have caused too many contractions and medication would be given to slow the contractions. It was safer to withhold than give too much.

Charge nurse Ms. Gallander testified that, after Respondent's shift, she reviewed her patients' records and noted:

- With Patient #1, Respondent made no record of the FHR between 1:09 p.m. and the end of her shift. The next FHR record was made at 6:15 p.m. by the next nurse.[31] Ms. Gallander testified that FHR should be recorded every 30 minutes and she would expect to see more documentation of the patient's vitals and the FHR.
- There was no cervical exam recorded between 3:05 p.m. and an 8:40 p.m. note that Patient #1 was pushing with contractions.[32] Ms. Gallander testified that cervical exams are largely at the discretion of the nurse and dependent on the specifics of a patient. Generally, they may take place approximately every two to three hours, but it may not be expected for this patient.

[31] Staff Ex. 7 at 17-19.

[32] Staff Ex. 7 at 18-19. The records do indicate that the doctor performed an examination of Patient #1 at 4:45 p.m., finding her fully dilated. Staff Ex. 8 at 18.

- Patient #1's records do not contain any nurse's notes by Respondent during her entire shift.[33] Ms. Gallander testified that it is unusual for a nurse to not take any notes for a patient for an entire shift.
- With Patient #2,[34] there is no record that Respondent administered Cytotec to the patient at 5:30 p.m.[35] Because of this uncertainty over the medication administered, the patient's next dose of Cytotec was withheld until 8:38 p.m.[36]

Ms. Dumas echoed Ms. Gallander's testimony that, when she reviewed Respondent's charting, she noticed that no FHR or contraction activity was recorded from 2:00 p.m. to about 5:30 p.m. for either patient. According to Ms. Dumas, it is unusual to not have that data charted for that length of time.

2. Seizure Disorder and Prior Incidents

Respondent has a diagnosed seizure disorder of which all the witnesses were aware.[37] Of the nurses present, only Ms. Dumas had previously witnessed Respondent have a seizure.[38] Ms. Dumas testified that she witnessed Respondent have two seizures, which were both similar. Prior to the seizure, Respondent fell ill and had to sit down and then the seizure happened a few minutes later. Ms. Dumas acknowledged other instances where she had conversations with Respondent and Respondent was not making sense, and Ms. Dumas would have to inquire whether

---

[33] *See* Staff Ex. 8 at 15.

[34] Patient #2 is identified in the records by MRN# 20068687.

[35] *See* Staff Ex. 20 at 6. In the medication record, the note indicates that the 5:30 p.m. dose of Cytotec was recorded as not given because of "uncertainty about whether [5:30 p.m.] dose was given or not." Staff Ex. 20 at 6.

[36] Staff Ex. 20 at 6. Prior doses were given at a frequency of approximately every two hours. Staff Ex. 20 at 5-6.

[37] Testimony of B. Cummings, S. Gallander, P. Niemann-Tuerk, K. Dumas, T. Halsall, S. Elizondo.

[38] Testimony of K. Dumas. Mses. Cummings, Gallander, Niemann-Tuerk, and Halsall testified that they had not witnessed Respondent have a seizure.

Respondent had a seizure. Ms. Elizondo described the management of Respondent's disorder and the side effects of her medication as a rollercoaster in the beginning. She felt that Respondent did not like her medication and tried to regulate it herself but did not have direct evidence that Respondent was not following her doctor's instructions.

After one seizure on the floor of the Unit, the nurses called rapid response and admitted Respondent as a patient in the Unit.[39] Ms. Elizondo felt this was not the proper way to address Respondent's seizures. So, after conversation, Ms. Elizondo, Ms. Dumas, and Respondent agreed that if Respondent had another seizure during her shift, she would be taken to the emergency department for treatment and a drug test. Ms. Elizondo described Respondent as "an open book" and comfortable with everyone knowing the plan. The other nurses testified that they were aware that, if she had a seizure at the Unit, Respondent was to be sent to the emergency department.

Ms. Dumas did not believe that the plan to send Respondent to the emergency department was any type of formal safety plan but rather a discussion and decision to remain diligent in talking about her disorder and any issues. Ms. Elizondo echoed this by stating that she had multiple conversations about the need to notify if something was going on, but she recognized that a person with a seizure disorder may not always realize that an episode is coming on.

[39] Testimony of S. Elizondo.

Respondent has previously appeared drowsy on her shift.[40] On those prior occasions, Respondent would work with management to find coverage for her patients and would ask to go home or lie down for a bit at the hospital.[41] These bouts of drowsiness would sometimes correspond with her taking her seizure medication.[42]

As for other prior issues, Respondent received a written warning on February 5, 2021, documenting potential issues with medications.[43] In late November or early December 2020, Respondent pulled two Norco tablets—a combination of Tylenol and a narcotic pain reliever—for a patient who was not present.[44] Ms. Elizondo testified that there was confusion over the addition of a new campus and several nurses pulled medication for the incorrect patient by room number and not by proper identification. The hospital was able to reconcile all but two medications: an antibiotic pulled by one nurse and the Norco pulled by Respondent. The written warning identified another prior instance where

[40] Testimony of S. Gallander; Ms. Gallander testified that Respondent's drowsiness on January 18, 2021, was worse than the previous times and she felt this was something different and bigger.

[41] Testimony of S. Gallander.

[42] Testimony of S. Gallander. Ms. Dumas testified that she took notes about Respondent's seizure disorder because there were concerns that it may interfere with her work. See Staff Ex. 6 at 26-29. On a couple of occasions, Respondent was sent home when she was drowsy and disoriented after taking her medication. Testimony of K. Dumas, P. Niemann-Tuerk. Staff Ex. 6 at 26.

[43] Staff Ex. 15 at 92. While the warning is dated after the incident, the majority of the incidents referenced are prior to January 18, 2021. Staff Ex. 6 at 92.

[44] Staff Ex. 15 at 92. In a letter dated March 22, 2021, Staff appears to have inquired about this late November/early December incident. Staff Ex. 2 at 1.

Respondent pulled two hydrocodone and never scanned them as given.[45] At the time, the patient was in labor and had no orders for hydrocodone.[46]

3. Fallout from January 18, 2021

Ms. Dumas testified that, at the request of Ms. Elizondo, she attempted to have Respondent drug tested prior to her leaving her shift on January 18, 2021. However, Respondent left the hospital before they could stop her. The drug test took place a few weeks later. The specimen was collected February 5, 2021, and the drug test was negative.[47]

Ms. Dumas and Ms. Elizondo stated that they were concerned, following this incident, about Respondent continuing to work in a high-risk, critical-care work environment where consistent attention to minute changes is required. Ms. Dumas came to believe that caring for critical-care patients would not be best for Respondent, because Respondent did not always have the ability to step back and assess her own capacity to practice. However, Ms. Dumas also acknowledged telling Respondent that the other nurses might be "setting [her] up" to look bad. Ms. Elizondo acknowledged that, when they first learned about a Board investigation, she and Respondent had a conversation where Ms. Elizondo indicated that it did not seem of large concern, and they had a negative drug test. At the same time, Ms. Elizondo testified, she was concerned about Respondent's

[45] Staff Ex. 15 at 92.

[46] Staff Ex. 15 at 92. The written warning also identifies a January 23, 2021, incident where Respondent gave a patient two Norco tablets for a pain level of 4 despite the medication being reserved for severe pain. Staff Ex. 15 at 92.

[47] Staff Ex. 15 at 120-21.

apparent deterioration and the nurses in the Unit were becoming more uncomfortable with and concerned about Respondent's performance.

Ms. Elizondo testified that, ultimately, she decided to put patient safety first despite a negative drug test and Respondent's doctor saying she was well enough to return. She testified that eventually many people came to her expressing concerns, though some were supportive of Respondent. Ms. Elizondo decided that Respondent could not return to labor and delivery but could practice at the hospital in an area requiring less critical care. Respondent was upset with the decision, stating that labor and delivery did not seem stressful because she was so familiar with it. Ms. Elizondo stated that they transferred her to women's health for postpartum cases, an assignment that generally required less acute care, and Respondent reluctantly agreed. She worked there for approximately two weeks, then called Ms. Elizondo from the parking lot at the start of her shift to say that she could not do it and it would not work out. Ms. Elizondo testified that during Respondent's time in the postpartum assignment, she did not want to interact with labor and delivery staff and seemed "checked out." Respondent applied for other positions in the hospital, but eventually left the hospital's employ.

4. Neuropsychological Evaluation and Testimony of Wayne Dees

Dr. Dees is a clinical neuropsychologist who was retained to evaluate Respondent.[48] Dr. Dees described the assessment as a substance-use evaluation with a neurological component that tests all domains of the brains using a variety of

[48] *See generally* Staff Ex. 5.

techniques to gauge its functioning.[49] The evaluation took place on September 17, 2021, with an intake meeting with Dr. Dees a week earlier and self-report questionnaires completed following the test day.

Dr. Dees testified that Respondent was prescribed: (1) Trokendi (taken daily) to manage her seizure disorder; (2) Lexapro (taken daily) for her depression; and (3) Ambien (taken as needed) for anxiety. Dr. Dees noted some inconsistencies between Respondent's answers given during the intake interview, on the life history forms, and on the post-evaluation questionnaire. In intake, Respondent stated that she was not particularly depressed and was not anxious about the Board case, considering it to be the product of complaints from a few nurses at the Unit with whom she had not gotten along. In the life history forms, Dr. Dees testified that Respondent reported that her anxiety was constant and she experienced panic attacks 99 times a month. And yet, on a screening scale for anxiety, Respondent's responses indicated low signs of situational and generalized anxiety.[50]

Through the evaluation, Dr. Dees identified some areas of neurological deficiency or concern. Dr. Dees found that Respondent demonstrated deficiencies in perceptual reasoning and processing speed—the ability to work quickly and efficiently.[51] Based on a self-report to determine the probability of having a substance dependence disorder, Dr. Dees's report states that Respondent's profile shows zero of nine rules correlated with a substance dependence disorder,

---

[49] *See* Staff Ex. 5 at 3-4.

[50] Staff Ex. 5 at 10.

[51] Staff Ex. 5 at 6.

indicating a low probability of Respondent having such a disorder.[52] On the primary personality scales, Dr. Dees noted that Respondent's profile contained indicators for histrionic and turbulent characteristics but found that she had good coping resources and adequate self-regulation of moods and emotions.[53] Dr. Dees found that Respondent's high level of energy could appear hypomanic, and could lead to depressive exhaustion as it became increasingly difficult to maintain the emotional intensity over time.[54]

Dr. Dees concluded that Respondent's symptoms were consistent with mild neurocognitive disorder, though the source was unknown.[55] He said it was possibly a result of the seizure disorder or a concussion Respondent sustained in 2018.[56] It could also be attributed to Respondent's seizure medications, which impair cognitive functioning and cause drowsiness, cognitive disruption, psychomotor slowing, and confusion.[57] Dr. Dees concluded that there was no clear indication of a substance use disorder.[58] He described a history of prescribed opioid use, but no past abuse or overuse.[59] He also found no clear indication of a personality disorder.[60] However, he testified that the neurological areas of weakness for Respondent raised concern over her ability to focus, pay attention, or multitask, as

---

[52] Staff Ex. 5 at 10.

[53] Staff Ex. 5 at 11.

[54] Staff Ex. 5 at 12.

[55] Staff Ex. 5 at 15.

[56] Staff Ex. 5 at 15.

[57] Staff Ex. 5 at 15.

[58] Staff Ex. 5 at 16.

[59] Staff Ex. 5 at 16.

[60] Staff Ex. 5 at 16.

well as her processing speed. This raised concern, in Dr. Dees's opinion, on her ability to perform in critical-care or high-risk units that may require quick action.

Dr. Dees's recommendations for Respondent are as follows: (1) be subject to case management and monitoring for not less than 12 months with significant oversight over her administration of prescribed medication to patients;[61] (2) consult or continue consulting with a neurologist regarding the seizure activity and cognitive deficits including work on cognitive rehabilitation; (3) consult with a sleep specialist to reduce her problematic sleep, which could be a factor in her seizures; (4) attend mental health counseling for 12 months to build coping resources, manage her depression and anxiety, and address her histrionic and turbulent personality patterns; (5) avoid critical care and emergency room settings as well as not work nights, overtime, on-call, rotating shifts, or float assignments; (6) be supervised and monitored for at least 12 months when administering controlled substances due to the possibility of diversion; (7) undergo random drug tests for the next 12 months; and (8) make it a practice to inform her supervisors if she is having difficulty managing her nursing duties or if she is feeling overwhelmed, having cognitive difficulties, or having problems tracking medication.[62]

Dr. Dees testified that stress and feelings of being harassed could trigger seizures and further strain Respondent's already weak cognitive functioning, so Respondent would need to feel safe enough with her supervisors to ask them to

[61] When asked, he testified that three years' monitoring would not be unreasonable.

[62] *See* Staff Ex. 5 at 16-17.

stop and reexplain something or give her written instructions when she is feeling overwhelmed.

5. Testimony of Elise McDermott

Ms. McDermott is the Board's nursing consultant. She is a registered nurse with experience in labor and delivery.[63] She is familiar with the statutes and rules governing nurses.

Ms. McDermott testified that it is the nurse's duty to ensure that they are fit to practice. When there are fitness-to-practice issues, the Board may look to monitor the nurse by prohibiting certain shifts and requiring drug testing.

Ms. McDermott opined that labor and delivery is a particularly critical area of nursing. It is a stressful situation for mother and unborn child. Ms. McDermott noted that both patients at issue were inductions (*i.e.*, their labors were induced rather than spontaneous) and had high blood pressure. Additionally, an unborn baby cannot be observed directly, so the safety of the baby is ensured through the careful monitoring of data like FHR. A nurse in labor and delivery must constantly monitor for trends and relationships between contractions and FHR. The labor is a series of constant changes to the baby and mother, so the data and records are necessary to trace what is or has been going on.

Documentation may also be necessary to accurately describe the patient's condition to the doctor, who may not be on the floor at the time. Accurately

---

[63] Staff Ex. 18 at 2.

recording medication doses is also important, as giving too much or too little may have serious consequences. In this case, Ms. McDermott noted there was confusion over Patient #2's dose of Cytotec, which creates artificial contractions. A patient who is given too much Cytotec may contract too much and additional medication may have to be administered to reduce contractions. If too little is given, the contractions may be too slow, which could prolong the labor and may increase risks associated with labor (*e.g.*, infection). In addition to the issue with Cytotec, the records do not indicate that Stadol was administered to Patient #2 despite being pulled by Respondent at 5:49 p.m.[64] Ms. McDermott stated recording the administration of a narcotic is important because it may make the unborn baby lethargic and the other nurses and doctors will need to determine whether the baby's behavior is the result of Stadol or something else.

Ms. McDermott concluded that Respondent violated Texas Occupations Code section 301.452(b)(10), (b)(12), and (b)(13). For each of the violations, Ms. McDermott applied the factors of the disciplinary matrix and recommended a second tier, second level sanction. For each violation, she ruled out the first tier because she found that there was some patient harm or risk of patient harm, and the first tier requires no risk of harm to the patient or patient involvement. She found that there could be some adverse effects to the patients. However, she determined that violations did not rise to the third tier, which requires serious or significant risk of harm or death.

[64] Staff Ex. 14 at 1; Staff Ex. 20 at 2.

Once arriving at a second-tier violation, Ms. McDermott testified that she looked to the aggravating and mitigating factors to determine her opinion as to the appropriate sanction level. With regard to subsection (b)(10), unprofessional conduct, Ms. McDermott opined that the aggravating factors were that (1) multiple patients were impacted despite it happening over one shift, (2) there was actual harm in the form of delay in pushing, prolonged labor, and increased risks, (3) there were other descriptions or complaints of lack of fitness and medication documentation issues, and (4) mothers and unborn babies are extremely vulnerable patients. She found a second level sanction appropriate but did not find that there was a need for revocation or enforced suspension.

Ms. McDermott repeated the exercise for the lack of fitness violation, subsection (b)(12), where she found similar aggravating factors in addition to the testimony of Dr. Dees and Ms. Elizondo describing what Ms. McDermott found to be a deterioration of Respondent's condition or ability. Ms. McDermott also relied on Ms. Elizondo's statement to conclude that Respondent was self-regulating her medication. Also, Respondent experienced multiple events or episodes, including at least two documented seizures at work. Ms. McDermott found a mitigating factor in Respondent's willingness to call in and self-report but concluded that the impairment had worsened to the point that Respondent might not be aware of her own fitness or lack thereof. Additionally, though the evaluation found a low chance of chemical dependency, Ms. McDermott thought there was some possible issue with Respondent's medicine use and concerns of medication diversion. As with the subsection (b)(10) violation, Ms. McDermott found that a probated suspension

would be appropriate and best for patient safety and not punitive toward Respondent.

Ms. McDermott repeated her analysis for the aggravating and mitigating factors for a subsection (b)(13). She found many of the same aggravating factors but found a mitigating factor specific to subsection (b)(13) applied: the patients' overall outcomes were not the result of Respondent's care. She testified that, while she concluded that Respondent's action may have caused some delay or risk to the patients, neither Patient #1 nor Patient #2 experienced an adverse outcome because of Respondent's care. Under the analysis for subsection (b)(13), Ms. McDermott again found the second sanction level to be appropriate.

Ms. McDermott opined that the appropriate sanction is a probated suspension for three years with one year of direct supervision and two years of indirect supervision. She found the following stipulations would be appropriate: requiring Respondent to complete remedial education in nursing jurisprudence and ethics, professional accountability, documenting, and critical thinking; prohibiting her from administering controlled substances for 12 months; barring her from critical care settings and rotating, overnight, or on-call shifts; requiring her to abstain from drugs and alcohol for a period of 12 months to be enforced through random drug tests; and mandating therapy as an outlet process and to form coping mechanisms.

B. Respondent's Evidence

Respondent testified that her seizure disorder emerged in 2016, and she has been open with others about her condition and treatment since the beginning. She stated that she is and has been compliant with her medication and, when she discusses it with her doctors, she wants to lower the dosage and does not ask for extra. She does not know what her seizures look like to others but knows what her seizures feel like. She noted that her seizures and the results of them are not always the same. They may be grand mal, or they may be small. After them, she sometimes suffers a period of confusion or disorientation, and may or may not be responsive to external stimuli and events.

Respondent does not have a memory of the afternoon of January 18, 2021, and does not deny that something happened. She testified that her actions on that date concern her as well; she was confused and does not remember how she got home.[65] If she had taken her medicine during her shift that day, she would have taken in the open as she had previously. She stated that she wants to take responsibility for her part, but she does not believe that she was able to control herself enough to remove herself from the situation. Respondent relied on and needed the assistance of the other nurses on the floor. If they had taken her to the emergency department for treatment as they were supposed to do, she would have taken a drug test as agreed with Ms. Dumas and Ms. Elizondo.

[65] She also testified of the added stressors she experienced in January 2021 with the approaching one-year anniversary of both her mother and her brother-in-law's death.

According to Respondent, the other nurses in the Unit were upset with her for the time she was missing from work beginning in early 2020 as she was taking care of her ill mother. She testified that she does not blame them, acknowledging that she was absent a lot and did not do her part in the Unit. However, Respondent said, the testimony about her changed behavior after returning from her vehicle and the insinuations of drug use were pure speculation and caused by her former coworkers' ill feelings toward her.

As for employment since leaving the hospital, Respondent testified that she worked in labor and delivery at a facility in Odessa from August 2021 to May 2022 before leaving her employment because of the commute and her concerns over this proceeding. She also testified that she has stopped taking Ambien.

When asked what she would do if faced with someone in a similar situation, Respondent did not agree that it should be reported. Instead, if it is a known issue, the person should be taken to the emergency room and treated. She said she would see it differently if her seizure disorder had not been well-documented and known to the other nurses. However, she acknowledged that in critical care, documentation is important and FHR and vital signs are always important. She also acknowledged that there is a risk to patients if their data is not documented for hours, and all patients deserve the best care. Respondent testified that she feels like she is safe to practice but cannot always identify when she is going to have a seizure. She acknowledged that it is her duty to ensure the safety of her patients but feels that the other nurses should also have a duty to monitor her fitness, similar to if she had a heart attack.

Respondent testified that a three-year probated suspension for someone with a documented medical condition is too long. She understands the Board's need to ensure patient safety and her fitness, but three years is not necessary.

IV. ANALYSIS

Staff alleges that, regardless of the reason for the impairment, Respondent was impaired on January 18, 2021, and, as a result, lacked fitness to practice and failed to properly record medical data for two patients. Respondent's defense is that any impairment was the result of a seizure, which she was unable to self-identify, and that the hospital failed to follow the protocol in place for when she had a seizure. As explained below, the ALJ finds Staff met its burden to demonstrate that Respondent violated the Nursing Practice Act and certain Board rules.

A. The Charges and Violations of Nursing Practice Act and Board Rules

The incident on January 18, 2021, is largely uncontroverted. Respondent reported for a six-hour shift at approximately noon on that date. At the time she arrived, she appeared alert and professional. Near the end of her shift, at approximately 5:00 p.m., she appeared lethargic and sleepy. She was unable to log in to the computer, was reminded by a staff member of a patient's overdue medication, and a doctor assisted Patient #1 in pushing during active labor when Patient #1 had been fully dilated for an hour and the doctor thought that Respondent should have been assisting the patient in pushing.

At the end of her shift, it was discovered that Respondent failed to record important medical data for her patients, including FHR, contractions, and other data for over three hours. For Patient #2, Respondent failed to record administering Cytotec and Stadol. Because of the confusion over its administration, the Cytotec dose was marked as "not given." Cytotec can have adverse effects if not given correctly. Failure to administer it at the designated times may prolong labor and increase risks of harm to both the mother and the child. Conversely, a patient given two doses of Cytotec may begin to contract too much, and other medication would be required to slow the contractions.

This evidence establishes that Respondent was impaired during her shift, which led to her lacking in fitness and failing to properly document her patients' medical data. She neglected to monitor and record the vital signs of her patients and failed to record the medication she administered at the end of her shift. This could have resulted in the misadministration of the medication if the patient had not spoken up about the medication she received.

As for Staff's first charge regarding lack of fitness, the evidence demonstrates that Respondent lacked fitness to practice on January 18, 2021, because of a mental or physical health condition that could result in injury to a patient or the public.[66] Additionally, Staff demonstrated that Respondent conducted herself unprofessionally as prohibited by subsection (b)(10) because Respondent demonstrated an inability to practice safely; accepted assignments that may have resulted in ineffective patient care; and could have endangered a

[66] Tex. Occ. Code § 301.452(b)(12).

patient's life, health or safety.[67] As for subsection (b)(13), Staff met its burden to demonstrate that Respondent failed to maintain minimum standards by failing to implement measures to promote a safe environment for patients.[68]

As for the Staff's second charge that Respondent failed to appropriately document patient assessment data in their medical records, Staff demonstrated that Respondent failed to maintain minimum standards because Respondent failed to accurately and completely document her patients' statuses, the nursing care rendered, and the administration of medications and treatment, as well as failed to implement measures to promote a safe environment for her patients.[69] Additionally, Respondent committed unprofessional conduct prohibited by Texas Occupations Code section 301.452(b)(10) by failing to conform to generally accepted nursing standards in the labor and delivery setting and performing conduct that may endanger a patient's health or safety.[70]

---

[67] Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(E), (4), (5). The ALJ does not find violations for the remaining violations of alleged Board rules as there is significant overlap between those rules and the minimum practice standards governed by Texas Occupations Code section 301.452(b)(13).

[68] Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(B). Similar to the above footnote, the ALJ finds that the remaining alleged rule violation overlaps significantly with the unprofessional conduct requirement to not accept assignments resulting in ineffective patient care.

[69] Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(B), (D).

[70] Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(B), (4). As noted above, the remaining rule violations alleged are best addressed through the violations of Respondent's minimum standard under Texas Occupations Code section 301.452(b)(13).

B. Appropriate Sanction and Applying the Disciplinary Matrix

Having found the violations, the next step is to determine the tier and level of the sanction. The ALJ finds that the appropriate sanction level for each violation is second tier, sanction level I.

1. The Second Tier Is the Appropriate Tier for All Violations

As for the sanction's tier, the ALJ agrees with the Board consultant that second tier is appropriate for each of the violations. Neither the first nor third tier is applicable in this case. For unprofessional conduct under (b)(10), the first tier is an isolated failure with no adverse patient effect, and the third tier requires the conduct to result in serious patient harm. For lack of fitness under (b)(12), the first tier requires no patient involvement or harm, and the third tier requires significant risk of harm or other serious practice violations. For the failure to adequately care or conform to minimum standard under (b)(13), the first tier requires a low risk of patient harm, and the third tier requires serious risk of harm or death. For each of these, the second tier requires some harm or risk but falls short of the serious or severe harm contemplated by the third tier. In this case, the violations consist of actions that resulted in some risk of harm. However, the evidence does not establish harm to a patient and the public or justify a third-tier sanction. Therefore, a second-tier sanction is appropriate.

2. Subsection (b)(10) Sanction Level: Aggravating and Mitigating Factors

Turning to the sanction level, the ALJ disagrees with Staff that the evidence justifies a second-level sanction. For (b)(10), the ALJ agrees that the aggravating factors of material or financial gain and criminal conduct are not applicable. While the laboring mothers and unborn children are extremely vulnerable, the actual harm and severity of harm are not aggravating in this case.

The testimonies support that delay in Cytotec administration may result in a prolonged or delayed labor, increasing a risk of harm. However, in this case, the evidence suggests that Respondent did administer the Cytotec. Even if she had not, the records show that the next dose of Cytotec was not administered until after 8:30 p.m.—over three hours beyond the "not given" dose, when all other doses were administered approximately two hours apart.[71] Presumably, if there were concerns of a delayed labor and increased risk of harm due to a delay in Cytotec administration, the subsequent nurse or doctor would ensure that Cytotec would be administered sooner than five hours from the last documented dose and three hours from the "not given" dose, when all other doses before and after that point were administered approximately two hours apart. The evidence does not establish the delay, if any, was caused by the lack of Respondent documenting the 5:30 p.m. Cytotec dose.

[71] This delay is even more inexplicable because the "not given" 5:30 p.m. dose was documented at 7:40 p.m., which would appear to have been an appropriate time to administer the next dose.

As for Patient #1, who was completely dilated for an hour prior to the start of active pushing, the records indicate that there were concerns of excessive bleeding postpartum. However, the evidence fails to establish that (1) an hour between dilation and active pushing was inappropriate in this situation or (2) the time between dilation and pushing caused the excessive bleeding. Ultimately, Dr. Wilson described Patient #1's delivery as "uneventful," and actual harm to the patient as a result of Respondent's actions is not established. The ALJ finds the actual harm and severity of harm factors do not aggravate the sanction in this case. Likewise, the ALJ also finds that the number-of-events factor does not significantly aggravate the sanction. The event was an impairment during the last few hours of Respondent's half shift.

As for prior complaints or discipline for similar conduct, there is some evidence of other concerns raised by the Unit's staff. However, the evidence is insufficient to establish that these should be an aggravating factor. First, there is no evidence of any prior Board action or discipline. Second, the evidence of the hospital's warning to Respondent is unclear, given that there was general confusion among nurses due to a new campus being added. Most importantly, the prior acts are not alleged in Staff's Formal Charges, which only address violations relating to her behavior on January 18, 2021. This is especially true for the late November/early December 2020 incident regarding the dispensed Norco tablets. Staff's letter to Respondent dated March 22, 2021, identifies this apparent incident as being a subject of investigation or inquiry, but Staff did not assert a violation in the Formal Charges. The ALJ finds unpersuasive the idea that an incident of which

Staff was aware and inquired but declined to bring Formal Charges should be given weight to aggravate the sanction of the charges brought.

Finally, for (b)(10) aggravating factors, the ALJ finds that the evidence does not establish that Respondent was impaired by alcohol, illegal drugs, or controlled substances or prescription medications, or that any of these were involved in this case. There is no direct evidence that Respondent abused or diverted any medication. As for the failure to document Stadol and concerns over its diversion, the patient and her family told Ms. Halsell that Respondent administered it. The record indicates that Respondent pulled the medication at 5:49 p.m. Her shift ended at 6:00 p.m., and Ms. Halsell testified that when she tried to get Respondent to record the information, Respondent was unable to log in to her account. The evidence preponderates toward Respondent administering the Stadol but failing to record it.

Likewise, there is little evidence of Respondent misusing her prescribed medication. Ms. Elizondo testified that Respondent's management of her seizure disorder at the beginning was a rollercoaster and said she suspected Respondent attempted to self-regulate her medication. However, Ms. Elizondo had no concrete evidence of misuse and there is little other evidence to suggest that Respondent was not compliant with her medication or that it caused or contributed to her impairment. Also, Dr. Dees's conclusions fail to support a basis for finding that drugs or alcohol played a role, finding a low probability of a substance dependence disorder.

As for mitigating factors, the ALJ agrees that there is no evidence of the mitigating factors found in the disciplinary matrix for subsection (b)(10). However, the ALJ finds that system dynamics in the practice setting contributed to the problem and weighs as a mitigating factor for the violations pursuant to 22 Texas Administrative Code section 213.33(c)(12). The evidence establishes that there was no formal plan or guidelines to handle Respondent's seizure disorder. The nurses were to send Respondent to the emergency department if she had a seizure. They did not do so in this case, and there appears to be no guidance to the nurses on the Unit of what to do in the absence of observing a traditional seizure. Furthermore, there is evidence of Unit politics or ill will playing a part in the actions of the nurses. Nearly all the nurses present who testified opined that they believed Respondent should have been removed. However, only one testified that she spoke to the Unit manager who was present at the shift that day, and only that nurse testified that she took any action to monitor the patients over concern of Respondent's fitness. For one nurse, she began recording Respondent's actions on her phone, instead of intervening or speaking to the Unit manager—who was present—to ensure the safety of the patients in the Unit. The charge nurse, despite believing that Respondent should have been removed, took no action. She did not speak to the Unit manager, intervene, remove Respondent, or find coverage to ensure patient safety. The system dynamics in the Unit contributed to the problem and is a mitigating factor in this analysis.

Applying the factors to this case, the ALJ finds that the factors do not support elevating to sanction level II. For subsection (b)(10), sanction level I is appropriate.

3. Subsection (b)(12) Sanction Level: Aggravating and Mitigating Factors

Similarly, for subsection (b)(12)'s factors, the factors do not support an elevation to sanction level II. The analysis set forth above for actual harm, severity of harm, and prior complaint or disciplinary conduct is equally applicable to this violation. As for the aggravating factors of seriousness of mental health diagnosis and number of events or hospitalization, there is evidence that Respondent's seizure disorder is a serious diagnosis, resulting in periods of confusion and disorientation. The evidence also establishes that Respondent has experienced several events, including two seizures documented at the hospital. In the analysis for this subsection, however, there are mitigating factors that weigh in favor of Respondent. Respondent has shown a willingness to self-report and be open with her condition and status. Additionally, Dr. Dees's evaluation of Respondent was overall positive. It indicates a low probability of substance use disorder. Dr. Dees found her fit with the implementation of certain stipulations to address her neurological deficiencies. For the subsection (b)(12) violation, a second tier, first level sanction is appropriate.

4. Subsection (b)(13) Sanction Level: Aggravating and Mitigating Factors

Finally, for subsection (b)(13), the disciplinary matrix lists many of the same aggravating factors as the previous subsection and the analysis above applies in equal force to these factors. The ALJ also agrees with the Board consultant that a mitigating factor does apply because the outcome to the patient was not the result

of Respondent's conduct. As noted above, the evidence fails to establish that either patient was actually harmed by Respondent's actions. Similarly, the outcomes of either patient cannot be said to the result of Respondent's failure to provide adequate care. For these reasons and the reasons above, second tier, sanction level I is appropriate for the subsection (b)(13) violation.

5. Staff and Dr. Dees' Recommended Disciplinary Action

As for the recommended disciplinary action and proposed stipulations, the ALJ agrees with Dr. Dees and the Board consultant that the stipulations should not be punitive but instead directed at addressing the concerns raised by the evidence and Dr. Dees's evaluation. Starting with Dr. Dees's testimony, the ALJ finds persuasive those recommendations that are within his area of expertise and rooted in his clinical findings. Given his assessment of a mild neurocognitive disorder, Dr. Dees's recommendations are well-founded regarding consultation with a neurologist and sleep specialist, attending counseling, avoiding stressful types of shifts, and having a plan of action for when Respondent feels overwhelmed. However, Dr. Dees's suggestions regarding drug testing and monitoring Respondent with significant oversight of her medication administration (particularly controlled substances) are inconsistent with his clinical conclusion that she has a low probability of a substance disorder. Dr. Dees found that Respondent took opioids as prescribed but had no history of abuse or overuse. Her profile showed zero of nine factors correlated with a substance dependence disorder. Apart from the speculation by her coworkers, there is no evidence she would misuse medications.

As for the Board consultant's recommendations, the ALJ similarly finds no evidence to support barring Respondent from administering controlled substances or requiring her to abstain from taking drugs or alcohol and be subject to drug testing. These stipulations would curtail the positions Respondent could hold and demand time and funds for a drug testing program that are not justified by the evidence.

With respect to the length and type of supervision required, the ALJ is unpersuaded that direct supervision is required, especially when Respondent would be restricted from taking positions in critical care or accepting shifts that could be stressful (floating, nights, on-call). Notably, the hospital did not suspend or terminate Respondent's employment or subject her to increased supervision immediately after the incidents at issue. Her doctor at the time cleared her to return to work and Ms. Elizondo was satisfied with a negative drug test. Instead, Ms. Elizondo and Ms. Dumas chose to move Respondent to a less demanding position and found that it was sufficient to ensure patient safety. Eventually, Respondent chose to leave the hospital's employ; she was not terminated. Ultimately, the sanction should be crafted to address the concerns demonstrated by the evidence—Respondent's ability to (1) work in high-stress, critical-care areas; (2) manage her seizure disorder, symptoms, and triggers; and (3) identify periods of impairment caused by her disorder and treatment. Staff's recommended sanctions for prolonged or direct supervision go beyond addressing these concerns and are not supported by the evidence or the factors listed in the disciplinary matrix.

Given the absence of justification for prolonged or direct supervision, the ALJ recommends a one-year warning with indirect supervision for the full duration. Also, the ALJ recommends stipulations that require Respondent to:

- complete remedial education in nursing jurisprudence and ethics, documentation, professional accountability, and critical thinking;
- not accept assignments in critical-care settings or for float, on-call, overtime, or night shifts;
- consult or continue consulting with a neurologist regarding the seizure activity as well as cognitive rehabilitation to address the cognitive deficits identified by Dr. Dees;
- consult or continue consulting with a sleep specialist to reduce her problematic sleep habits or inability to sleep;
- attend mental health counseling for 12 months aimed toward building coping resources, managing her depression and anxiety, and addressing her histrionic and turbulent personality patterns; and
- at the time she delivers the Board order to an employer, speak to the employer about her seizure disorder and the symptoms she may experience from it as well as developing written guidelines or procedures for the management of her seizure disorder, which, at a minimum, should contain a process by which Respondent may self-report symptoms or seizures, how Respondent and other staff should handle a seizure or potential effects of a seizure during the shift, the process by which Respondent should be removed from duty including when a drug test should be performed, and when such a process should be triggered.

Substance use stipulations or restrictions are not recommended because the evidence does not establish that drugs, alcohol, or other substances played a relevant part in the violations.

V. FINDINGS OF FACT

1. Safarahh McMillan (Respondent) received Registered Nurse (RN) License No. 735461 from the Texas Board of Nursing (Board) in 2006.

2. Respondent has a diagnosed seizure disorder, which she manages through medication.

3. On January 18, 2021, Respondent work a shift as an RN from noon to 6:00 p.m. in the labor and delivery unit (Unit) at Shannon Women's and Children's Hospital in San Angelo, Texas.

4. At approximately 5:00 p.m. that day, Respondent showed signs of impairment, including extreme drowsiness and lethargy, an inability to log into the computer system, and slurred speech.

5. Respondent completed her shift and left. Respondent does not recall the events of the afternoon or how she arrived home.

6. On that day, Respondent lacked fitness to practice nursing.

7. Respondent failed to remove herself from her shift despite her impaired behavior.

8. Respondent's seizure disorder was known to her colleagues. If she had a seizure while on duty, the other nurses in the Unit were supposed to take Respondent to the emergency department for treatment and a drug test.

9. Other nurses in the Unit reported Respondent's behavior to management, including the Unit Manager and the administrative director. However, none of the nurses attempted to take Respondent to the emergency department.

10. The charge nurse for the shift neither took any action to remove Respondent from duty nor reported her observations to the Unit Manager or other member of management.

11. The Administrative Director referred the report to the Unit Manager to handle it.

12. At the time, the Unit Manager did not believe Respondent to be impaired and took no action to remove Respondent.

13. On that day, Respondent failed to appropriately document or chart two patients' vital signs including cervical exams and FHR.

14. Respondent failed to document a 5:30 p.m. administration of Cytotec for a laboring patient.

15. The medical records document the 5:30 p.m. dose as "not given" because it was not recorded by Respondent, but the patient stated that Respondent had administered the medication.

16. Cytotec is a drug used to cause or increase contractions in a mother to induce or speed up labor.

17. Delay in administering Cytotec may prolong labor and increase risks to both the mother and unborn baby. Conversely, excessive doses of Cytotec may cause too many contractions, requiring other medications to be administered to slow the contractions.

18. For this patient, Cytotec was administered approximately every two hours.

19. The nurse following Respondent did not administer the next dose of Cytotec until approximately 8:30 p.m.—three hours beyond the 5:30 p.m. dose documented as "not given."

20. For the same patient, Respondent pulled Stadol—a narcotic pain reliever—at 5:49 p.m. but did not record its administration. The patient and her family confirmed that Respondent administered the medication.

21. While there is some risk of harm for the failure to record the administration of Cytotec and Stadol, there was no demonstration of actual harm to the patient because of the failure to document. To the extent that the patient had prolonged labor, the evidence does not establish that Respondent's failure to document the Cytotec dose lengthened the labor.

22. While there was a risk of harm due to Respondent's failure to record the vital signs, including cervical exams and FHR, there is no evidence that the failure to record the vital signs caused any actual harm.

23. For another patient, the records indicate labor onset at 3:00 p.m. on January 18, 2021, with complete dilation at 4:57 p.m. and pushing started at 5:55 p.m. The doctor expected Respondent to be assisting the patient with pushing prior to 5:55 p.m.; however, when Respondent did not, the doctor helped the patient push.

24. A one-hour difference between complete dilation and active pushing may be appropriate if the patient is a first-time mother like this patient.

25. The evidence does not establish that a one-hour difference between complete dilation and active pushing was inappropriate for this patient.

26. With this patient, there were postpartum concerns of excessive bleeding.

27. The evidence does not establish that excessive bleeding was the result of a delay to begin pushing.

28. The evidence does not establish that there was any actual harm or harm of any severity to either of the patients.

29. The outcomes of the patients were not the result of Respondent's failure to adequately care.

30. After the incident on January 18, 2021, the hospital continued to employ Respondent and there is no evidence that Respondent was subject to increased supervision.

31. The Administrative Director moved Respondent to women's health for postpartum cases, an assignment requiring less acute care.

32. Respondent worked briefly in the postpartum care assignment. She applied for other positions at the hospital but eventually left its employ.

33. Respondent was subject to a neuropsychological evaluation, which concluded that Respondent was fit to practice nursing with certain limitations or stipulations. The evaluation also found a low probability that Respondent has a substance use disorder.

34. Respondent took a drug test on February 5, 2021, and it was negative.

35. The evidence is insufficient to establish that Respondent's impairment on January 18, 2021, was related to, the result of, or involved the use of drugs or alcohol, including prescribed medication or controlled substances.

36. Staff issued its Second Amended Notice of Hearing to Respondent on May 19, 2022. The Second Amended Notice of Hearing 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.

37. State Office of Administrative Hearings (SOAH) Administrative Law Judge (ALJ) Brent McCabe convened the hearing on the merits via Zoom videoconference on July 11, 2022. Assistant General Counsel JoAnna Starr represented Staff. Respondent appeared and represented herself. The record closed on July 14, 2022, with the filing of the admitted exhibits.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. 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. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

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

4. Staff had the burden of proof by a preponderance of the evidence, and Respondent had the burden of establishing any mitigating factors. 1 Tex. Admin. Code § 155.427.

5. Respondent's actions constitute unprofessional conduct because she did not conform to generally accepted nursing standards, accepted assignments which were reasonably expected to result in ineffective client care,

performed conduct that may have endangered a patient's life, health, or safety, and demonstrated an inability to practice safely. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(B), (1)(E), (4), (5). As a result, Respondent is subject to sanction by the Board.

6. Respondent lacked fitness to practice nursing because of a mental or physical health condition that could result in injury to a patient or the public. Tex. Occ. Code § 301.452(b)(12). As a result, Respondent is subject to sanction by the Board.

7. Respondent actions fell below the minimum standards of acceptable nursing practice because she did not promote a safe environment for patients and did not accurately or completely document patients' medical data. Tex. Occ. Code § 301.452(b)(13) (2021 ver., since amended) (renumbered as (b)(14) as of September 1, 2021); 22 Tex. Admin. Code § 217.11(1)(B), (D). As a result, Respondent is subject to sanction by the Board.

8. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

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

10. For a violation under section 301.452(b)(10), the Board may consider as an aggravating factor: patient vulnerability. 22 Tex. Admin. Code § 213.33(b)-(c).

11. For a violation under section 301.452(b)(10), Respondent established and the Board may consider as a mitigating factor: the extent to which system dynamics in the practice setting contributed to the problem. 22 Tex. Admin. Code § 213.33(b)-(c).

12. For a violation under section 301.452(b)(12), the Board may consider as aggravating factors: seriousness of mental health diagnosis and number of events. 22 Tex. Admin. Code § 213.33(b)-(c).

13. For a violation under section 301.452(b)(12), Respondent established and the Board may consider as mitigating factors: self-report, positive psychological/chemical dependency evaluation, and the extent to which system dynamics in the practice setting contributed to the problem. 22 Tex. Admin. Code § 213.33(b)-(c).

14. For a violation under section 301.452(b)(13), the Board may consider as an aggravating factor: patient vulnerability. 22 Tex. Admin. Code § 213.33(b)-(c).

15. For a violation under section 301.452(b)(13), Respondent established and the Board may consider as mitigating factors: outcome not a result of care and the extent to which system dynamics in the practice setting contributed to the problem. 22 Tex. Admin. Code § 213.33(b)-(c).

VII. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends a one-year warning with indirect supervision for the full duration, with stipulations that require Respondent to:

- complete remedial education in nursing jurisprudence and ethics, documentation, professional accountability, and critical thinking and other topics the Board deems beneficial;
- not accept assignments in critical-care settings or float, on-call, overtime, or night shifts;
- consult or continue consulting with a neurologist regarding the seizure activity as well as cognitive rehabilitation to address the cognitive deficits identified by Dr. Dees;
- consult or continue consulting with a sleep specialist to reduce her problematic sleep habits or inability to sleep;

- attend mental health counseling for 12 months aimed toward building coping resources, manage her depression and anxiety, and address her histrionic and turbulent personality patterns; and

- at the time she delivers the Board order to an employer, speak to the employer about her seizure disorder and the symptoms she may experience from it as well as developing written guidelines or procedures for the management of her seizure disorder, which, at a minimum, should contain a process by which Respondent may self-report symptoms or seizures, how Respondent and other staff should handle a seizure or potential effects of a seizure during the shift, the process by which Respondent should be removed from duty including when a drug test should be performed, and when such a process should be triggered.

SIGNED SEPTEMBER 12, 2022.

Brent McCabe,

Presiding Administrative Law Judge