



I do hereby certify this to be a complete, accurate and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Kristin K. Benton, DNP, RN
Kristin K. Benton, DNP, RN
Executive Director
Texas Board of Nursing

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of § AGREED ORDER
Registered Nurse License Number 865209 and § FOR
Privilege to Practice Nursing from Indiana § KSTAR PROGRAM
Registered Nurse License Number 28235830A §
issued to ALIREZA POURABEDINI

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of ALIREZA POURABEDINI, Registered Nurse License Number 865209 and Privilege to Practice Nursing from Indiana Registered Nurse License Number 28235830A, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(14)(effective 9/1/2021), and 304.0015, Article 5, Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order for KSTAR Program approved by Kristin K. Benton, DNP, RN, Executive Director, on October 2, 2023.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s)/privilege to practice from the State of Indiana.
2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order for KSTAR Program.
3. Respondent's license to practice as a professional nurse in the State of Texas is in delinquent status. Respondent's license to practice as a professional nurse in the State of Indiana, a party state in the Nurse Licensure Compact, is in current status.

4. Respondent received a Baccalaureate Degree in Nursing from Shahid Beheshti University, Tehran, Iran, on March 10, 1994. Respondent was licensed to practice professional nursing in the State of Texas on September 23, 2014, and was licensed to practice professional nursing in the State of Indiana on May 18, 2017.

5. Respondent's nursing employment history includes:

9/2014 – 10/2016	Registered Nurse	Kasra Hospital Tehran, Iran
11/2016 – 3/2017	Unknown	
4/2017 – 7/2017	Registered Nurse	Lutheran Hospital Fort Wayne, Indiana
1/2018 – 3/2018	Registered Nurse	Regional Health Hospital Rapid City, South Dakota
4/2018 – 6/ 2018	Unknown	
7/2018 – 8/2021	Registered Nurse	Elkhart General Hospital Elkhart, Indiana
9/2021 – 5/2022	Unknown	
6/2022 – 8/2022	Registered Nurse	UT Southwestern Medical Center Dallas, Texas
9/2022 - Present	Registered Nurse	East Community Hospital Indianapolis, Indiana

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, using a Privilege to Practice professional nursing from the State of Indiana, and had been in that position for two (2) months.

7. On or about August 14, 2022, while utilizing a Privilege to Practice Nursing from the State of Indiana, and assigned to UT Southwestern Medical Center, Dallas, Texas, Respondent inaccurately documented a heparin infusion rate of 1,380 units per hour for Patient MRN70059528, instead of an increased Heparin rate of 1,680 units per hour as per titration orders. Subsequently, when a new Heparin infusion was prepared, the Heparin pump automatically pulled the Respondent's incorrectly documented data from the MAR, and the correct administration rate was not verified by Respondent. Respondent's conduct created an inaccurate medical record and exposed the patient to a risk of harm in that failure

to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's condition.

8. On or about August 16, 2022, while utilizing a Privilege to Practice Nursing from the State of Indiana, and assigned to UT Southwestern Medical Center, Dallas, Texas, Respondent failed to completely and accurately document nursing interventions after Patient MRN9492913 complained of pain at a peripheral intravenous vascular (PIV) site, including elevation of the affected hand and application of an ice pack. Respondent's conduct resulted in an incomplete medical record and was likely to injure the patient in that subsequent care givers would not have accurate and complete information on which to base their care decisions.
9. On or about August 20, 2022, while utilizing a Privilege to Practice Nursing from the State of Indiana, and assigned to UT Southwestern Medical Center, Dallas, Texas, Respondent inappropriately administered Osmolite to Patient MRN93704251 through the patient's Dobhoff tube, instead of Nepro as per physician orders. Respondent inaccurately documented Nepro was infusing. The oncoming shift noted Osmolite was infusing through the patient's Dobhoff tube. Respondent's conduct created an inaccurate medical record and exposed the patient to a risk of harm in that failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment of the patient's condition.
10. On or about August 27, 2022, while utilizing a Privilege to Practice Nursing from the State of Indiana, and assigned to UT Southwestern Medical Center, Dallas, Texas, Respondent failed to appropriately intervene for aspiration risk Patient MRN94426940, in that Respondent failed to reconnect the patient's Gastrostomy (G-tube), and Jejunostomy (J-tube) tubing to the proper ports. As a result, the patient's nutritional feeding was incorrectly administered via the G-tube into the patient's stomach instead of the small intestine. Respondent's conduct exposed the patient to risk of injury from adverse complications of improperly administered tube feedings, including aspiration.
11. In response to the incident in Finding of Fact Number Seven (7), Respondent states when his Preceptor turned the Heparin pump back on, it reverted to its original setting. In response to the incident in Finding of Fact Number Eight (8), Respondent states the patient did not complain of pain at the PIV until after the Dilaudid administration. In response to the incident in Finding of Fact Number Nine (9), Respondent states only the dietician order was labeled and ready for the patient. In response to the incident in Finding of Fact Number Ten (10), Respondent states the markings on the port were not clearly visible when he reattached the tubing.
12. Formal Charges were filed on July 18, 2023.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11 (1)(A),(1)(B),(1)(C),(1)(D),(1)(M)&(1)(P), and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)(B),(1)(C)&(4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(14)(effective 9/1/2021), and 304.0015, Article 5, Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 865209 and Privilege to Practice Nursing from Indiana Registered Nurse License Number 28235830A, heretofore issued to ALIREZA POURABEDINI.
5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **WARNING WITH STIPULATIONS** 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.

II. COMPLIANCE WITH LAW

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

III. KNOWLEDGE, SKILLS, TRAINING, ASSESSMENT AND RESEARCH (KSTAR) PROGRAM

IT IS AGREED and ORDERED that RESPONDENT SHALL, **within one (1) year of the effective date of this Order**, successfully complete the Knowledge, Skills, Training, Assessment and Research (KSTAR) Program and RESPONDENT SHALL:

- A. **Within forty-five (45) days** following the effective date of this Order, apply to and enroll in the KSTAR Program, including payment of any fees and costs, unless otherwise agreed in writing;
- B. Submit to an individualized assessment designed to evaluate RESPONDENT'S nursing practice competency and to support a targeted remediation plan;
- C. Follow all requirements within the remediation plan, if any;
- D. Successfully complete a Board-approved course in Texas nursing jurisprudence and ethics as part of the KSTAR Program; and
- E. Provide written documentation of successful completion of the KSTAR Program to the attention of Monitoring at the Board's office.

IV. FURTHER COMPETENCY ISSUES AND VIOLATIONS

IT IS FURTHER AGREED, SHOULD RESPONDENT'S individualized KSTAR Program assessment identify further competency issues and violations of the Nursing Practice Act, including inability to practice nursing safely, further disciplinary action, up to and including revocation of RESPONDENT'S license(s) to practice nursing in the State of Texas, may be taken based on such results in the assessments.

V. RESTORATION OF UNENCUMBERED LICENSE(S)/PRIVILEGE(S) TO PRACTICE

Upon full compliance with the terms of this Agreed Order for KSTAR Program, 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.

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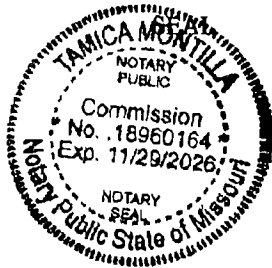
RESPONDENT'S CERTIFICATION

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

Signed this 5 day of October, 2023

Alireza
ALIREZA POURABEDINI, RESPONDENT

Sworn to and subscribed before me this 5 day of October, 2023



[Signature]
Notary Public in and for the State of Missouri

Approved as to form and substance.
[Signature]
Dan Lype, Attorney for Respondent

Signed this 5 day of October, 2023

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order for KSTAR Program that was signed on the 5th day of October, 2023, by ALIREZA POURABEDINI, Registered Nurse License Number 865209 and Privilege to Practice Nursing from Indiana Registered Nurse License Number 28235830A, and said Agreed Order for KSTAR Program is final.

Effective this 14th day of November, 2023.

Kristin K. Benton, DNP, RN

Kristin K. Benton, DNP, RN
Executive Director on behalf
of said Board