BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED ORDER
Registered Nurse License Number 986210	§	FOR
issued to GLENISHA MARIE WILLIAMS	§	KSTAR PROGRAM
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considerec the matter of GLENISHA MARIE WILLIAMS, Registered Nurse License Number 986210, 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)&(13)*[effective through 8/31/21]*, 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 September 8, 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).

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 current status.

4. Respondent received an Associate Degree in Nursing from East Arkansas Community College, Forrest City, Arkansas, on May 1, 2009. Respondent was licensed to practice professional nursing in the State of Texas on February 11, 2020.

5. Respondent's nursing employment history includes:

6/2009- 7/2009	Unknown	
8/2009- 3/2011	Registered Nurse	NEA Baptist Memorial Hospital Jonesboro, Arkansas
3/2011- 4/2017	Registered Nurse	Methodist University Hospital Memphis, Tennessee
5/2017- 10/2018	Registered Nurse	Regional One Medical Center Memphis, Tennessee
9/2018- 9/2019	Registered Nurse	Saint Thomas West Hospital Nashville, Tennessee
9/2019- 2/2020	Registered Nurse	Medical City Plano Plano, Texas
10/2019- 2/2020	Registered Nurse	UT Southwestern Medical Center Dallas, Texas
Unknown	Registered Nurse	HCA Houston Healthcare West Houston, Texas
7/2020- Present	Registered Nurse	Houston Methodist Hospital Houston, Texas
2/2021- Present	Registered Nurse	Memorial Hermann Hospital Houston, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, and had been in that position for two (2) months.

7. On or about December 28, 2019, while employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, Respondent incorrectly administered insulin from the wrong insulin sliding scale to Patient JB (MRN 92275950) during continuous tube feeding. Respondent failed to assess and/or timely treat the patient's elevated blood glucose level at 243 mg/dl at 2138 by administering two (2) units of Insulin Aspart (Novolog) instead of the ordered seven (7) units. Further, Respondent failed to administer Insulin Aspart (Novolog) of nine (9) units at 0051 per physician order for a blood glucose of 286, instead of the administered three (3) units. Finally, Respondent failed to assess and/or timely administer Insulin Aspart (Novolog) to the patient at 0400. Instead, Respondent administered three (3) units of Insulin at 0552 for a blood glucose level of 286 when the

ordered dose was nine (9) units. Respondent's conduct was likely to injure the patient from complications of elevated blood sugar, including nerve damage and ketoacidosis and could have resulted in non-efficacious treatment.

8. On or about January 3, 2020, while employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, Respondent incorrectly titrated Insulin for Patient MR (MRN 70095493) at 2029 to 4 mg/dl and again at 2100 to 6 mg/dl, but did not assess the blood sugar until 2112; then increased the titration rate to 10 mg/dl at 0200 but did not assess the blood glucose level from 0120 until 0214. In addition, Respondent failed to assess and/or document the patient's blood glucose level every one (1) hour from 0359 to 0553, per the physician order, after the Insulin was titrated from 10 mg/dl to 5 mg/dl. Respondent's conduct was likely to injure the patient in that failure to administer Insulin as ordered by the physician could have resulted in complications from uncontrolled blood glucose levels.

9. On or about February 9, 2020, while employed as a Registered Nurse with UT Southwestern Medical Center, Dallas, Texas, Respondent failed to titrate IV Vasopressin for Patient TA (MRN 72375862) to keep the patient's Mean Arterial Pressure (MAP) greater than 55, per the physician's order. Instead, Respondent increased the rate from 0.01 units/min to 0.04 units/min at 1300 when the patient had a Mean Arterial Pressure (MAP) documented at 87 mmHg, without medical indication. Respondent's conduct was likely to injure the patient in that failing to administer the Vasopressin as ordered by the physician could have resulted in the Mean Arterial Pressure (MAP) raising too high and the patient suffering adverse reactions including blood clots, heart attack, and/or a stroke.

10. In response to the incident in Finding of Fact Number Seven (7), Respondent states she was in phase two of orientation. Respondent states glucocorticoids are typically given to cardiac/transplants patients after surgery and enteral continuous feeds are usually ordered with an insulin drip to manage glucose levels. Respondent states the sliding scale of insulin can differ by 2-4 units whether a patient is receiving an enteral feed or not. In response to the incident in Finding of Fact Number Eight (8), Respondent states that she has been a critical care nurse since 2009. Respondent states the sliding scale protocol was different at this facility. Respondent states she remembers titrating from the wrong category, but her preceptor noticed, and corrections were made. No patient harm happened. In response to the incident in Finding of Fact Number Nine (9), Respondent states she was on phase three of orientation. Respondent states the event was a matter of charting in real-time. Respondent states she was overwhelmed and took notes of the titrations to document later. Respondent states she had a new preceptor that didn't know she made notes and planned to document later. Respondent states she was behind about four (4) of her titration times for the Cardene and Vasopressin.

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)(N),(1)(P)&(3)(A) 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)&(13)*[effective through 8/31/21]*, Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 986210, heretofore issued to GLENISHA MARIE WILLIAMS.

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)**

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.

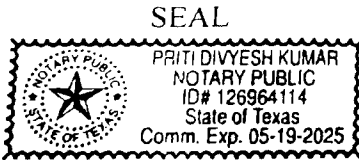BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that 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 23 day of 10 , 20 23.

GLENISHA MARIE WILLIAMS, RESPONDENT

Sworn to and subscribed before me this 23rd day of October, 20 23.

SEAL

Notary Public in and for the State of TX

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby

ratify and adopt the Agreed Order for KSTAR Program that was signed on the 23rd day of October,

2023, by GLENISHA MARIE WILLIAMS, Registered Nurse License Number 986210, and said

Agreed Order for KSTAR Program is final.

Effective this 14th day of November, 2023.

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