BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Vocational Nurse License Number 220738	§	
issued to JESSICA HARDMAN COZART	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JESSICA HARDMAN COZART, Vocational Nurse License Number 220738, 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)(1)&(10), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Kristin K. Benton, DNP, RN, Executive Director, on October 15, 2024.

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.

3. Respondent's license to practice as a vocational nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from Texas State Technical College West Texas, Sweetwater, Texas, on December 13, 2008. Respondent was licensed to practice vocational nursing in the State of Texas on February 24, 2009.

5. Respondent's nursing employment history includes:

2/2009 – 7/2013	Licensed Vocational Nurse	Stephens Memorial Hospital Breckenridge, Texas

Respondent's nursing employment history continued:

8/2013 – 8/2014	Licensed Vocational Nurse	Snyder Oaks Snyder, Texas
11/2014 – 7/2015	Licensed Vocational Nurse	Cedar Crest Breckenridge, Texas
7/2015 – 9/2015	Licensed Vocational Nurse	Tri-Star Home Health Breckenridge, Texas
9/2015 – 11/2015	Licensed Vocational Nurse	Cisco Nursing Home Cisco, Texas
11/2015 – 3/2016	Licensed Vocational Nurse	Villa Haven Health and Rehabilitation Center Breckenridge, Texas
4/2016 – 2/2017	Unknown	
3/2017 – Unknown	Licensed Vocational Nurse	Angels of Care Abilene, Texas
6/2022 – Unknown	Licensed Vocational Nurse	The Eden of Las Colinas Irving, Texas 75062
9/2024 – Present	Licensed Vocational Nurse	The Woodlands Assisted Living Eastland, Texas

6. On or about December 1, 2015, Respondent was issued the sanction of Remedial Education with Fine through an Order of the Board. A copy of the December 1, 2015, Order is attached and incorporated herein by reference as part of this Agreed Order.

7. On or about December 12, 2017, Respondent was issued the sanction of Warning with Stipulations through an Order of the Board. A copy of the December 12, 2017, Order is attached and incorporated herein by reference as part of this Agreed Order.

8. On or about January 21, 2021, Respondent was issued the sanction of Reprimand with Stipulations through an Order of the Board. A copy of the January 21, 2021, Order is attached and incorporated herein by reference as part of this Agreed Order.

9. On or about January 21, 2022, Respondent failed to successfully complete a Board-approved course in medication administration as required by Section III, Subsection B,

Remedial Education Course(s), of the Opinion and Order of the Board issued on January 21, 2021.

10. Formal Charges were filed on December 19, 2022.

CONCLUSIONS OF LAW

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

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.12(11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(1)&(10), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 220738, heretofore issued to JESSICA HARDMAN COZART.

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, subject to ratification by the Texas Board of Nursing, that Vocational Nurse License Number 220738, previously issued to JESSICA HARDMAN COZART, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this Order.

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

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

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

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

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.

III. COMPLIANCE WITH PRIOR ORDER

The Opinion and Order of the Board issued to RESPONDENT on January 21, 2021, is still in effect in its entirety and RESPONDENT SHALL be responsible for completing the terms of that Opinion and Order of the Board and any outstanding Remedial Education Courses required in the January 21, 2021 Opinion and Order of the Board must be completed within six (6) months from the effective date of this Agreed Order.

IV. 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.

V. MONETARY FINE

RESPONDENT SHALL **pay a monetary fine in the amount of five hundred dollars ($500.00) within forty-five (45) days of the effective date of this Order.** Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

VI. EMPLOYMENT REQUIREMENTS

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

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

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

"Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

VII. CONSEQUENCES OF CONTINUED NONCOMPLIANCE

Continued noncompliance with the unfulfilled requirements of this or any Order previously issued by the Texas Board of Nursing, as applicable, may result in further investigation and subsequent disciplinary action, including denial of licensure renewal or revocation of RESPONDENT'S license(s) and/or privileges to practice nursing in the State of Texas.

VIII. FURTHER COMPLAINTS

If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IX. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed 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.

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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 25 day of October, 2024.

JESSICA HARDMAN COZART, RESPONDENT

Sworn to and subscribed before me this _____ day of _____, 20____.

SEAL

Notary Public in and for the State of _____

[redacted]

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 25th day of October, 2024, by JESSICA HARDMAN COZART, Vocational Nurse License Number 220738, and said Agreed Order is final.

Effective this 10th day of December, 2024.

Kristin K. Benton, DNP, RN

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

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.

Executive Director of the Board

DOCKET NUMBER 507-20-2852

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 220738, ISSUED TO JESSICA HARDMAN COZART	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: JESSICA HARDMAN COZART
201 CR 156
EASTLAND, TX 76448

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 21-22, 2021, 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 that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) and (13)[1]. Either a Warning with Stipulations or a Reprimand with Stipulations is authorized under a second tier, sanction level I sanction[2]. The Board agrees with the ALJ that a Reprimand with Stipulations is the most appropriate sanction in this case.

Respondent's committed multiple violations of the Nursing Practice Act and Board rules, and her conduct placed patients at a risk of harm[3]. Further, the Respondent has prior disciplinary action with the Board and prior discipline by the Respondent's employer for similar conduct[4].

Although the Respondent's conduct was risky, there was no evidence of serious harm actually occurring[5]. Additionally, patients had positive comments about the Respondent; the Respondent successfully completed the facility's remediation; and she has positive subsequent practice[6].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(3), that a Reprimand with Stipulations is the most appropriate sanction in this matter.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a documentation course, a critical thinking course, and a medication administration course[7]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board also agrees with the ALJ that the Respondent's practice should be directly supervised for the first year of the Order, and indirectly supervised for the remainder of the Order. The Board further finds it appropriate to prohibit the Respondent from working in independent practice settings, like home health or hospice, and from being employed temporarily by agencies during the pendency of the Order. The Board also finds the Respondent should be prohibited from working in a critical care setting or on night shifts for the first year of the Order. These supervisory requirements are intended to prevent additional violations from occurring and to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The Board also agrees with the ALJ that the Respondent should be required to inform her

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[1] See pages 15-16 of the PFD.

[2] See 22 Tex. Admin. Code §213.33(b).

[3] See pages 15-16 of the PFD.

[4] See page 16 of the PFD.

[5] See *id.*

[6] See *id*

[7] 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.

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 requirements are consistent with 22 Tex. Admin. Code §213.33(e)(4)[8].

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

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

[8] 22 Tex. Admin. Code §213.33(e)(4), which authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

malpractice issues will not be accepted. Home study and video programs will not be approved.

B. **A Board-approved course in medication administration** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

C. **A Board-approved course in 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.

D. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) 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 eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until

eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

C. **Direct Supervision.** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited. Additionally, RESPONDENT SHALL not practice as a nurse on the night shift or 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.

D. **Indirect Supervision:** For the remainder of employment as a Nurse under this order, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and

readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and, 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 21st day of January, 2021.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; Docket No. 507-20-2852 (September 11, 2020)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

September 11, 2020

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

RE: Docket No. 507-20-2852; Texas Board of Nursing v. Jessica H. Cozart, LVN.

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507, a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,

Pratibha J. Shenoy
Administrative Law Judge

PS/db
Enclosures

xc: Helen Kelley, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS**

Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD of Hearing on the Merits) – **VIA EFILE TEXAS and INTERAGENCY MAIL**

Jessica H. Cozart, 201 CR 156, Eastland, TX, 76448 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-20-2852

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
JESSICA H. COZART, LVN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Board) seeks to sanction the Licensed Vocational Nurse (LVN) credential held by Jessica H. Cozart (Respondent) because she failed to comply with educational requirements of a prior Agreed Order, and based on allegations of substandard practice and unprofessional behavior in patient care, medication administration, and documentation, among other issues. Staff argues Respondent should be sanctioned with a Reprimand and a two-year Order with stipulations. The Administrative Law Judge (ALJ) concludes that Staff proved its allegations by a preponderance of the evidence and recommends the Board issue a Reprimand and Order with terms described below.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

ALJ Pratibha J. Shenoy convened a telephonic hearing on the merits on July 9, 2020. Assistant General Counsel Helen Kelley represented Staff, and Respondent represented herself. The record was held open to allow Respondent to submit certificates of completion for educational courses, but she made no submissions and the record was closed on July 17, 2020.

Matters of notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion.

II. STAFF'S FORMAL CHARGES AND APPLICABLE LAW

The Texas Nursing Practice Act, found in chapter 301 of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, a violation of a Board

order (Code § 301.452(b)(1)), unprofessional conduct (Code § 301.452(b)(10)), or practice below minimum standards of nursing case (Code § 301.452(b)(13)). Staff asserted that Respondent's conduct is grounds for disciplinary action under all three Code provisions, as well as pursuant to a number of Board rules.[1] With respect to unprofessional conduct, Staff asserts Respondent failed to comply with:

- **Board Rule 217.12(1)(A)**: careless or repeated failure or inability to practice in conformity with minimum standards set out in Board Rule 217.11.[2]
- **Board Rule 217.12(1)(B)**: failing to conform to generally accepted nursing standards in applicable practice settings.
- **Board Rule 217.12(1)(C)**: improper management of client records.
- **Board Rule 217.12(4)**: conduct that may endanger a client's life, health, or safety.
- **Board Rule 217.12(6)(A)**: falsifying reports, client documentation, agency records or other documents.
- **Board Rule 217.12(6)(G)**: misappropriating, in connection with the practice of nursing, anything of value or benefit, including but not limited to, any property, real or personal of the client, employer, or any other person or entity, or failing to take precautions to prevent such misappropriation.
- **Board Rule 217.12(6)(H)**: providing information which was false, deceptive, or misleading in connection with the practice of nursing.
- **Board Rule 217.12(10)(C)**: failing to follow the policy and procedure in place for the wastage of medications at the facility where the nurse was employed or working at the time of the incident(s).
- **Board Rule 217.12(11)(B)**: Violating an order of the Board (among other things).

With respect to minimum standards of nursing practice, Staff alleges Respondent did not comply with provisions that require a nurse to:

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[1] For ease of reference, the Board's rules, found in title 22, chapters 211 to 228 of the Texas Administrative Code, shall be referred to in the text as "Board Rule ____."

[2] A number of subsections of Board Rule 217.12 were amended effective October 17, 2019, but the subsections cited in this Proposal for Decision were unaffected.

- **Board Rule 217.11(1)(A)**: know and conform 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.

- **Board Rule 217.11(1)(B)**: implement measures to promote a safe environment for clients and others.

- **Board Rule 217.11(1)(C)**: know the rationale for and the effects of medications and treatments and correctly administer the same.

- **Board Rule 217.11(1)(D)**: accurately and completely report and document required matters, including client status, care rendered, doctors' orders, medications and treatments administered, client response, and contacts with other members of the health care team.

- **Board Rule 217.11(1)(O)**: implement measures to prevent exposure to infectious pathogens and communicable conditions.

- **Board Rule 217.11(2)**: meet standards specific to LVNs, including utilization of a systematic approach to providing goal-directed nursing care (including data collection, focused nursing assessments, planning and modifying nursing care plans, and implementing care within an LVN's scope of practice), assigning tasks to unlicensed personnel with proper supervision, and performing other tasks commensurate with the LVN's experience, continuing education, and demonstrated competencies.

Board Rule 213.33 sets out a disciplinary matrix (Matrix) intended to match the severity of the sanction imposed to the nature of the violation, taking into account mitigating and aggravating factors listed in the Matrix.[3] The Matrix categorizes violations into tiers and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. Board Rule 213.33 includes another list of factors that the Board and the State Office of Administrative Hearings (SOAH) must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[4]

[3] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[4] 22 Tex. Admin. Code § 213.33(c).

Staff had the burden of proving its allegations by a preponderance of the evidence, and Respondent has the burden of proving mitigating factors, if any.[5]

III. DISCUSSION

Staff called four witnesses including Respondent, who also testified on her own behalf. Staff's eight exhibits were admitted without objection. The majority of Staff's 13 charges in this case relate to the observations made by two LVN nursing students who shadowed Respondent during her shifts on February 27-28, 2019. The students, Lorna Copeland and April Clark, wrote detailed statements immediately after their shifts and provided notarized copies of the statements to the Board; they also testified at the hearing.[6] To facilitate the discussion, the ALJ has indicated in the text the charge numbers from Staff's First Amended Formal Charges, attached to its Notice of Hearing. Charges related to the prior Agreed Order are discussed last.

A. Evidence

1. Testimony of Lorna Copeland, LVN

Ms. Copeland arrived at Cisco Nursing and Rehabilitation (Facility) in Cisco, Texas, at approximately 6 a.m. on February 28, 2019, to shadow Respondent for a six-hour shift. She testified that she did not leave the Facility until the shift was over, and Respondent was the only nurse she followed for that clinical rotation. When Ms. Copeland arrived, Respondent was not yet there, even though the shift began at 6 a.m. Respondent got to the Facility at 6:30 a.m. and, according to Ms. Copeland, distributed just a few medications for some of the residents before she left for about 40 minutes to have coffee with her father-in-law.

When Respondent returned, Ms. Copeland continued following her on the medication rounds. As they went to residents' rooms with the medication cart, Ms. Copeland noticed a number

[5] 1 Tex. Admin. Code § 155.427.

[6] The statements are contained in Staff Exhibit 8. Ms. Copeland and Ms. Clark provided testimony at the hearing that tracked their written statements closely. The testimony and statements are quoted without differentiation unless specifically noted.

of things that "shocked" her. According to Ms. Copeland, Respondent said she did not need to consult the patient medication lists because she had them memorized, and began "popping out multiple pills . . . directly into her hand" instead of into medication cups (Charge 6). The proper technique, Ms. Copeland testified, is to ensure safety by checking each medication against the patient's prescription, and to ensure sanitation by opening the pill into a medication cup. Ms. Copeland added that Respondent's hands "looked dirty," and she never saw Respondent wash or sanitize her hands between patients.

Respondent then gave a blister pack of pills to Ms. Copeland and instructed her to open them into a medication cup. One pill bounced off the cup and fell on the floor, Ms. Copeland said, so she asked Respondent what she should do. Respondent picked up the pill and threw it into the trash instead of disposing of it in a biohazard container (Charge 7). One patient had a prescription for Furosemide 20 milligrams (mg),[7] and Ms. Copeland noted that the patient's allotted prescription had run out. Respondent took a Furosemide 20 mg pill out of a blister pack labeled for another patient and gave it to the first patient (Charge 8). Asked about Respondent's claim (discussed below) that the medication cart had an overstock supply of prescription drugs that could be allocated to patients as needed, Ms. Copeland testified that she has never heard of such a practice and said it would be contrary to proper medication control and documentation.

Ms. Copeland testified that she also observed Respondent give 8:00 a.m. and 12:00 p.m. medications to several patients at the same time (Charge 9) and administer other drugs to patients "2-3 hours late" (Charge 10). These actions created a risk to the patients, Ms. Copeland explained, because physicians prescribe the time(s) of drug doses to stabilize a disease process, and doubling up doses or delaying medications can thwart this goal as well as pose overdose risks.

Finally, Ms. Copeland noted what she described as a number of documentation and assessment errors by Respondent. Respondent was flipping through the medication log and came upon a page where she had not logged and initialed administering drugs for patients three days earlier. Ms. Copeland said that drugs are supposed to be logged contemporaneously with

[7] Furosemide is a diuretic used to treat conditions such as edema.

administration, but she watched as Respondent logged and initialed the incomplete forms for the earlier shift (Charge 2). According to Ms. Copeland, Respondent also charted edema level and pain level "before ever laying eyes on the patient" and actually assessing the patient (Charge 11).

When cross-examined by Respondent, Ms. Copeland said she did not challenge Respondent on the spot because it was her first clinical experience and she was too intimidated to speak up. However, Ms. Copeland added, she texted and/or called her nursing instructor multiple times during the shift and reported everything she saw as it was unfolding.

Ms. Copeland worked for a doctor before going to nursing school and said she knew about proper medication handling and documentation from that experience, as well as from school. She had never met Respondent before the clinical rotation and had no reason to dislike her or to try to create trouble for her. That evening, Ms. Copeland felt "extremely sick to [her] stomach" and decided she "couldn't sleep" if she did not do something about what she had seen, so she wrote down all of her observations and submitted them to her instructor. Ms. Copeland testified that she is now working as a nurse, takes pride in her profession, and is troubled to think of the reputational harm to all nurses when one nurse is as "careless" as Respondent. She said it saddens her that "there are people out there [like Respondent] treating the elderly like this."

2. Testimony of April Clark, LVN

Ms. Clark attended a rotation at the Facility on February 27, 2019, and joined other LVN students in observing and assisting Respondent with an open-wound dressing change for a patient. Ms. Clark said that proper technique is to wash or sanitize one's hands, go into the patient's room, place the sterile packaging on a clean surface, and open it at the bedside. She testified that she did not see Respondent wash her hands before going into the room but conceded that she might have missed it. However, she said, she did observe very troubling conduct by Respondent that she detailed in her written statement, as follows:

> [Respondent] showed us what she would be packing the open wound with and then proceeded to open the sterile package containing wet, sterile gauze, in the hallway without proper procedure being followed . . . . She pulled out scissors from her

> medication cart, without disinfecting them either, and cut the gauze. Then, she held up the gauze with both hands, without using any gloves, to show us what it looked like and then set it back onto the open package. Because her hands were saturated, she then wiped her hands on her scrubs, which clearly are not sanitized [Charge 12].[8]

When the group entered the patient's room, the patient turned onto her side so the wound, which was in her gluteal area, could be accessed. Ms. Clark said they discovered that the patient had had a bowel movement in her brief. She testified that the correct procedure would have been to leave the wound dressing unopened in its sterile package at the bedside, clean up the patient, wash one's hands, and then change the dressing on the wound. Instead, Respondent placed the already-opened package on the bedside table without sanitizing the surface, pulled down the brief, and removed the wound dressing before cleaning up the feces. Uncovering the wound exposed it to infection from fecal matter, Ms. Clark explained. She added that the situation was worsened because Respondent used wipes to clean off the feces and then cleaned the wound with a wipe that "was already soiled with the patient's stool" (Charge 13).

Next, according to Ms. Clark, Respondent changed her gloves but did not sanitize or wash her hands; sprayed and cleaned the wound; and used the previously-opened gauze to pack the wound before applying a bandage to cover it. At that point, Respondent "instructed [the students] to press the call light so the [Certified Nurse Aide, or CNA] may finish removing the brief and change it because as a nurse, she had better things to do." Ms. Clark said she and a classmate volunteered to do it themselves and Respondent replied, "If that's what you want to do, then go ahead." The two students finished cleaning the patient, dressed her in a fresh brief, and changed the bed linens, which had gotten stained from the wound leaking through the dressing. When they were done, Ms. Clark stated, the patient was "very grateful." Ms. Clark was left with the impression that "this kind of care was not provided as often as it needs to be."

Ms. Clark said she did not know Respondent, had not met her before that day, and did not have ill will toward her. However, she was upset to see that the patients at the Facility, most of

[8] Staff Ex. 8 at 2.

whom already had compromised immune systems, were being put at more risk by Respondent's improper infection control.

3. Respondent's Testimony

Respondent expressed great frustration that the shadow clinical rotations had "made [her] life a living hell" based on what she said were misperceptions and false accusations. Respondent testified that at first, she was excited to have the students observe her so she could "pay it forward" to the profession. However, she learned about the statements from Ms. Copeland and Ms. Clark about two weeks after the rotations, when she could not defend herself properly and demonstrate how the students had misinterpreted her actions.

For example, Respondent said, she told the students to open pills into a medication cup, and "*not* into your hand," and they may have misheard her. If Ms. Copeland had asked about the Furosemide 20 mg tablet that she alleged was given to one patient out of a different patient's prescription, Respondent could have explained that there is an "overstock" section on the medication cart that had additional doses of various prescription drugs. She testified that she took two Furosemide 10 mg tablets from the overstock and gave it to the patient whose prescription had run out, so neither patient was deprived of a dose.

With respect to Ms. Clark's description of the wound dressing change, Respondent testified that she had been taking care of that patient for around eight months, and when she started, the wound was "big enough to put your fist in it." By the time the students observed her in late February 2019, the wound had healed to roughly a square inch in size. If she truly had been so deficient in her infection control and methods, Respondent pointed out, it did not make sense that the patient had made that much progress.

Staff questioned Respondent about other documentation issues from the February 28, 2019 shift. She agreed she initialed the charts of two patients, P.L. and T.I., indicating she administered metoprolol, a blood pressure medication, during the 8:00 a.m. medication pass. She also confirmed that vital signs must be taken before metoprolol is administered, because it can be dangerous if

given to a patient whose blood pressure and pulse are already low. However, the spaces where she should have recorded each patient's pulse and blood pressure were blank (Charge 3).[9] Respondent said that it must have been an oversight on her part for patient P.L., because she always checked vital signs before giving the medication. For patient T.I., Respondent testified, she was sure she had checked his vital signs because "he's such a character," and she remembered their interactions. Yet, she conceded, she had not made an entry to confirm that she had performed patient T.I.'s weekly skin evaluation that was due that day (Charge 4),[10] and patient T.I.'s oxygen saturation was not recorded though she documented administering oxygen (Charge 5).[11]

On cross-examination, Respondent acknowledged that she had received three written counseling warnings from the Facility before the February 2019 incidents. She was admonished on September 21, 2018, because she failed to write down physician orders, transcribe them into a medication record, and order the prescribed drugs from the pharmacy in a timely fashion as required by Facility policy.[12] On October 12, 2018, Respondent was counseled because she did not follow Facility policy and complete an accident and incident report or progress note to document a resident's fall.[13] On December 31, 2018, Respondent was counseled because she was late to work twice (on December 27 and 31, 2018).[14]

The Facility suspended Respondent on March 7, 2019, pending an investigation conducted by the Facility Administrator, Charles Walters. Mr. Walters completed a "Provider Investigation Report" form (Report) required by the Texas Health and Human Services Commission (HHSC). The Report states that a nursing instructor alleged Respondent "had been routinely late in administering medications to residents on her hall." Mr. Walters interviewed Facility staff and five residents who were assigned to Respondent and who were sufficiently "alert and oriented."[15] The

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[9] Staff Ex. 6 at 655, 689.

[10] Staff Ex. 6 at 684.

[11] Staff Ex. 6 at 694.

[12] Staff Ex. 6 at 18.

[13] Staff Ex. 6 at 19.

[14] Staff Ex. 6 at 20.

[15] Staff Ex. 6 at 26.

statements made by Ms. Copeland and Ms. Clark are mentioned in the narrative attached to the Report, but they were not interviewed. Mr. Walters concluded in the Report that there was evidence Respondent was "late or inconsistent" when administering medication but found insufficient evidence that she "was outside the one-hour time frame for administering medications."[16]

On March 8, 2019, Mr. Walters closed his investigation and held a conference call with HHSC staff to decide the appropriate action plan. Per the Report, it was decided that Respondent could be allowed to return to work if she agreed to a "final written warning" with stipulations.[17] Respondent signed the warning form on March 11, 2019, and resumed working at the Facility.[18] The stipulations required Respondent to be monitored by another nurse for a month, at least twice weekly during medication rounds and at least once a week during wound care. Also, Respondent was required to arrive with sufficient time before the start of her shift to take a report from the outgoing nurse, to notify certain personnel at any time she took a break or left the building, and to not take her break until her morning medication pass was completed.[19] Respondent testified that she successfully met these stipulations and continues to work at the Facility.

Despite the prior counseling and the warning, Respondent emphasized that she is a good nurse and her skills have been recognized by patients and their families. She pointed to statements made to Mr. Walters during his investigation. For example, one patient said Respondent was "stressed and gets sidetracked" and sometimes late with morning medication, but added that Respondent "treats me so good [and she] is very caring."[20] Another patient, "Mrs. P," was mentioned in Ms. Copeland's statement as not receiving a pain pill for a long time despite requesting one from Respondent.[21] Mr. Walters determined the allegation was unfounded, and it is not included in Staff's Formal Charges. In fact, Mrs. P's daughter told Mr. Walters, "with tears

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[16] Staff Ex. 6 at 26.

[17] Staff Ex. 6 at 31.

[18] Staff Ex. 6 at 21-22.

[19] Staff Ex. 6 at 22.

[20] Staff Ex. 6 at 28.

[21] Staff Ex. 8 at 4.

in her eyes," that Respondent "goes way beyond for my momma," and there was no reason to believe Mrs. P was getting anything less than excellent care.[22]

Respondent opined at the hearing that the Report is evidence the students were not qualified to judge her practice. She speculated that they may have been seeking attention by making dramatic claims. Additionally, according to Respondent, Ms. Copeland was "not there for half the shift" despite asserting that she observed the entire six hours. Respondent noted that three different CNAs who worked at the Facility said Respondent regularly notified them whenever she left for a break and that they did not worry about being able to find her.[23]

Respondent was first licensed in Texas in 2009. There are two prior Agreed Orders between Respondent and the Board. The first order, effective December 1, 2015 (2015 Order), concerned Respondent's allegedly incorrect answers to questions regarding her criminal history when she submitted license renewal forms in August 2013 and August 2015.[24] Respondent was required to complete remedial education and pay a fine. She successfully completed the 2015 Order.[25]

The second Agreed Order took effect December 12, 2017 (2017 Order), and resulted in the issuance of a Warning with Stipulations and a fine. Staff alleged that in March 2016, Respondent misappropriated a patient's medication to give to a CNA who was complaining of nausea; signed out controlled substances for eight patients but failed to document administering the drugs; and failed to administer and/or document administration of medication to 23 patients.[26] As with the first order, Respondent signed a statement neither admitting nor denying the allegations, but agreeing to a sanction to avoid further disciplinary action.[27]

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[22] Staff Ex. 6 at 32.

[23] Staff Ex. 6 at 21-22.

[24] Staff Ex. 4 at 21-27. The ALJ notes that the order includes a statement that Respondent agreed to the entry of the order to avoid further disciplinary action and neither admitted nor denied the allegations. Staff. Ex. 4 at 26.

[25] Staff Ex. 4 at 12 (documenting completion of the 2015 Order).

[26] Staff Ex. 4 at 12-13.

[27] Staff Ex. 4 at 19.

The 2017 Order required Respondent to pay a fine of $250 within 45 days and complete Board-approved courses in nursing jurisprudence, medication administration, nursing documentation, and critical thinking, within one year. Respondent also agreed to work for four quarterly periods (excluding periods of unemployment or any quarter in which all three months were not with the same employer) with stipulations including notifying her employer about the 2017 Order; working with indirect supervision (by a nurse present on the grounds but not necessarily on the same unit); and causing her employer to submit quarterly nursing evaluations on Board-approved forms. At the hearing, Staff alleged that Respondent had not completed the educational portion of the 2017 Order (Charge 1), but Respondent stated that she had taken some courses and had certificates of completion she would provide. As previously noted, the record was held open to allow Respondent to submit her certificates, but she made no submissions.

4. Testimony of Elise McDermott, BS, MS, RN

Ms. McDermott is the Lead Nursing Consultant for Practice at the Board and was accepted by the ALJ as an expert on the Board's rules and policies.[28] She testified as to the sanctions the Board may consider in this case, based on the assumption that the ALJ would find Staff met its burden to establish the underlying facts. Among other things, Ms. McDermott pointed out that there are multiple provisions of the Code that could apply in this case depending on the facts proven, including Code § 301.452(b)(1) (violation of a Board order), (b)(10) (unprofessional conduct), and (b)(13) (practice below minimum standards of nursing care). Correspondingly, numerous Board rules would be implicated based on the misconduct at issue. Ms. McDermott testified that, in a situation involving multiple violations, the Board's Matrix directs the ALJ and the Board to consider the most serious conduct and the more severe sanction.

In Respondent's case, Ms. McDermott stated, more attention would be given to the unprofessional standards and substandard practice allegations rather than Respondent's failure to complete the educational requirements of the 2017 Order. Under either Code § 301.452(b)(10) or (b)(13), Ms. McDermott opined that a Second Tier, Sanction Level I disciplinary action would be appropriate, with issuance of a two-year Order and a Reprimand with stipulations. To the extent

[28] Ms. McDermott's curriculum vitae is contained in Staff Ex. 7.

Ms. McDermott's testimony was accepted by the ALJ, it is generally incorporated into the analysis below without citation.

B. Analysis

1. Conduct Established

The ALJ finds that Staff proved all of its 13 Formal Charges by a preponderance of the evidence. On one hand, Respondent testified she did not do the things Ms. Copeland and Ms. Clark claimed to have observed, and Mr. Walters's Report to HHSC found insufficient evidence that Respondent was outside a one-hour window for medication administration. However, the ALJ gives greater weight to the testimony and sworn statements submitted by Ms. Copeland and Ms. Clark. Neither witness had met Respondent before, and they had no incentive to foment trouble for Respondent. As students, they risked negative repercussions to their own future careers for making such serious allegations against a nurse with a long practice history. Their testimony at the hearing was credible and consistent with their contemporaneous statements. Both witnesses exhibited a deep concern for the welfare of patients at the Facility as well as the harm to the nursing profession caused by Respondent's conduct.

Respondent's testimony was much less specific, consisting mostly of general denials and assertions that the students either misheard or deliberately misrepresented her actions. She conducted very limited cross-examination of Ms. Copeland and Ms. Clark, stating that she was too upset to be sure she could remain professional. Respondent's claim regarding an overstock area of the medication cart undermines the foundational concept of controlling the supply, dispensing, and documentation of prescription medications that is required by the Code and Board rules, and the ALJ finds it unpersuasive.

The ALJ notes that the medication administration and documentation allegations in this case are similar to those in the 2017 Order (though Respondent did not admit to the truth of the charges in that order). More importantly, Staff proved that Respondent was twice counseled in late 2018 for failure to complete documentation in accordance with Facility policy. Staff also established documentation deficiencies in medication administration, taking and/or recording vital

signs, completing a skin evaluation, and measuring and/or recording oxygen saturation (Charges 3-5) that were independent of the assertions made by Ms. Copeland and Ms. Clark but occurred on the same shift(s). Finally, although Mr. Walters found Ms. Copeland's and Ms. Clark's allegations to be unfounded, the ALJ does not give great weight to his conclusions given that he is the Facility Administrator, conducted his entire investigation in one day, and did not document any interviews of Ms. Copeland or Ms. Clark.

The ALJ finds that Staff proved conduct supporting disciplinary action under the following Code provisions and Board Rules:

- **Failure to comply with a Board Order** (Charge 1): Code § 301.452(b)(1), (10); Board Rule 217.12(11)(B).

- **Failure to contemporaneously record administration of medication; back-dating medication records** (Charge 2): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (D), 217.12(1)(A), (B), (C), (4).

- **Administering metoprolol prior to assessing and/or recording pulse and blood pressure for two patients** (Charge 3): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (D), 217.12(1)(A), (B), (4).

- **Failure to perform and/or document weekly skin assessment for a patient** (Charge 4): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4).

- **Failure to assess and/or document oxygen saturation for a patient** (Charge 5): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4).

- **Failure to follow proper infection control and medication administration techniques in opening pills into her hand instead of medication cups** (Charge 6): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (O), 217.12(1)(A), (B), (4).

- **Improperly disposing of medication in a trash can instead of in a biohazard container consistent with employer policy** (Charge 7): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), 217.12(1)(A), (B), (4), (10)(C).

- **Misappropriation of Furosemide 20 mg tablet from one patient and administering it to another patient** (Charge 8): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4), (6)(G).

- **Administration of 8:00 a.m. and 12:00 p.m. medications at the same time to multiple patients** (Charge 9): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4).

- **Administering scheduled medications to multiple patients two to three hours late** (Charge 10): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4).

- **Documenting edema and pain levels before seeing and assessing the patient** (Charge 11): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (2), 217.12(1)(A), (B), (4), (6)(A), (H).

- **Opening sterile wound care supplies without wearing gloves, cutting sterile gauze with scissors that had not been disinfected, and placing supplies on a surface that had not been sanitized** (Charge 12): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (O), 217.12(1)(A), (B), (4).

- **Removing bandage on a wound prior to performing perineal care after patient had a bowel movement, using a wipe that was already stained with feces to clean the wound, and using unsterile gauze to pack the wound** (Charge 13): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (O), 217.12(1)(A), (B), (4).

2. Sanction Analysis

Whether Respondent's most serious conduct is analyzed as unprofessional conduct prohibited by Code § 301.452(b)(10) or as a failure to meet the minimum practice standards set out in Code § 301.452(b)(13), a Second Tier, Sanction Level I classification is appropriate under the Matrix given Respondent's prior disciplinary history and the number of substantive violations established. The First Tier of the Matrix for either Code section addresses isolated failures to comply with Board rules concerning unprofessional conduct with no patient risk or adverse effects (Code § 301.452(b)(10)) and practice below the standard of care with a low risk of patient harm (Code § 301.452(b)(13)). Respondent's conduct was not isolated, and it risked patient health.

The Third Tier under Code § 301.452(b)(10) encompasses unprofessional behavior that results in serious harm to a patient or the public, and the Third Tier under Code § 301.452(b)(13) is meant to address substandard practice with a serious risk of harm or death that is known or should be known or a significant demonstration of incompetence. The evidence does not show

actual, serious harm, and Respondent's behavior was shown to be risky but not to the point of being potentially fatal. Thus, the Third Tier under either Code section is inappropriate.

Within the Second Tier, Sanction Level I is the best fit for the conduct shown. Sanction Level II under either Code provision contemplates license denial, suspension, or revocation, and Staff did not contend that level of disciplinary action is appropriate. Sanction Level I proposes a Warning or Reprimand with stipulations. Since Respondent has already received a Warning (in the 2017 Order), the Matrix directs that the more severe sanction of a Reprimand should be imposed. With respect to the stipulations accompanying the Reprimand, the ALJ agrees with Ms. McDermott's recommendations: classes in medication administration, jurisprudence, documentation, critical thinking, and other subjects the Board deems proper; a requirement that Respondent provide a copy of the Order and Reprimand to her employer and cause the employer to send quarterly performance reviews to the Board; and one year of work with direct supervision, followed by one year of work with indirect supervision, with a prohibition on critical care positions and night shifts for the first year.

The ALJ finds the following aggravating factors may be considered by the Board: the number of events; prior disciplinary action by the Board; disciplinary action by Respondent's employer for conduct similar to that at issue in this case; and patient vulnerability. In addition, the ALJ finds the following mitigating factors apply: no evidence of serious harm to patients; the positive comments provided by patients to Mr. Walters, even when the patients also acknowledged Respondent's shortcomings; the fact that Respondent has practiced since 2009; Respondent's successful completion of the stipulations imposed by the Facility when she returned to work in March 2019; and her subsequent practice without any known complaints.

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

IV. FINDINGS OF FACT

1. Jessica H. Cozart (Respondent) was issued Licensed Vocational Nurse (LVN) License No. 220738 by the Texas Board of Nursing (Board) in 2009.

2. Effective December 1, 2015, the Board and Respondent entered into an Agreed Order (2015 Order) that imposed a sanction of remedial education and a fine based on Respondent's allegedly incorrect answers to questions regarding her criminal history when she submitted license renewal forms in August 2013 and August 2015. Respondent successfully completed the 2015 Order.

3. Effective December 12, 2017, the Board and Respondent entered into a second Agreed Order (2017 Order). The 2017 Order stemmed from allegations that Respondent misappropriated a patient's medication to give to a Certified Nurse Assistant (CNA) who was complaining of nausea; signed out controlled substances for eight patients but failed to document administration of the drugs; and failed to administer and/or document administration of medication to 23 patients. The 2017 Order resulted in the issuance of a Warning with Stipulations that required Respondent to pay a fine of $250; complete Board-approved courses in nursing jurisprudence, medication administration, nursing documentation, and critical thinking within one year; and work for four quarterly periods with stipulations including notifying her employer about the 2017 Order, working with indirect supervision, and causing her employer to submit quarterly evaluations.

4. Respondent has not yet submitted proof of completion of the educational requirements of the 2017 Order.

5. On February 28, 2019, Lorna Copeland, a student in an LVN program, arrived at Cisco Nursing and Rehabilitation (Facility) in Cisco, Texas, to shadow Respondent for a clinical rotation.

6. Respondent was late to start her 6:00 a.m. shift and left for a break before completing her morning medication round.

7. Respondent popped multiple pills for patients out from blister packs into her hand instead of medication cups. Medication cups are properly used to maintain sanitation and infection control.

8. A pill fell on the ground, and Respondent threw it in a trash can, where it could be misappropriated or misused, instead of safely disposing of it in a biohazard container.

9. One patient was out of a prescription for Furosemide 20 milligrams (mg), and Respondent opened a blister pack labeled for another patient and gave the dose to the first patient.

10. In Ms. Copeland's presence, Respondent back-dated entries for medication logs from a shift three days earlier. Medication logs are properly completed contemporaneously with administration.

11. Respondent charted edema and pain levels for a patient before entering the patient's room and assessing the patient.

12. Respondent was two to three hours late in administering medications to some patients, and gave some patients their 8:00 a.m. and 12:00 p.m. medications at the same time. Drugs are prescribed to be given at specific times to stabilize disease processes, and late administration or a double dose can thwart this goal and/or pose a risk of overdose.

13. On February 27, 2019, Respondent was shadowed for a portion of her shift by another LVN nursing student, April Clark. Ms. Clark and other students were assigned to observe and assist with a wound dressing change for a patient.

14. Respondent opened the sterile wound dressing while in the hallway, held up the wet, sterile gauze to show the students, cut the gauze without first disinfecting her scissors, and wiped her wet hands on her scrubs.

15. Wound dressing should be kept sterile until the nurse is prepared to change the dressing and places the package on a sanitized surface.

16. When the group entered the patient's room, the patient turned on her side so her wound, in her gluteal area, could be accessed. Respondent and the students then noted that the patient had had a bowel movement in her brief.

17. Respondent placed the already-opened wound dressing package on the bedside table without first sanitizing the surface. She removed the old dressing from the wound before cleaning up the feces and used a wipe that was stained with feces to wipe the wound.

18. Exposing the wound before the bowel movement was cleaned raised the risk of infection, as did the use of a soiled wipe on the wound.

19. Without washing or sanitizing her hands, Respondent then changed her gloves, sprayed and cleaned the wound, and used the previously-opened gauze to pack the wound before applying a bandage to cover it.

20. Respondent directed the students to call for a CNA to complete the brief change for the patient. Instead, Ms. Clark and another student finished cleaning the patient, changed her stained bed linens, and put a fresh brief on her.

21. In her documentation for February 28, 2019, Respondent initialed the charts of two patients, P.L. and T.I., to indicate she administered metoprolol, a blood pressure medication, during the 8:00 a.m. medication pass. However, Respondent either did not take or did not record vital signs for the two patients.

22. Metoprolol can be dangerous if administered to a patient whose blood pressure and pulse are already low.

23. Respondent either did not perform or did not record results of a weekly skin evaluation for patient T.I., which was due to be completed on February 28, 2019.

24. Respondent either did not measure or did not record patient T.I.'s oxygen saturation, but she documented administering oxygen on February 28, 2019.

25. On September 21, 2018, the Facility issued written counseling to Respondent because she failed to write down physician orders, transcribe them into a medication record, and order the prescribed drugs from the pharmacy in a timely fashion as required by Facility policy.

26. On October 12, 2018, Respondent received written counseling because she did not follow Facility policy and complete an accident and incident report or progress note to document a resident's fall.

27. On December 31, 2018, Respondent received written counseling because she was late to work twice that month.

28. Ms. Copeland and Ms. Clark were both upset and shocked by their observations of Respondent's nursing practice. Each wrote a statement contemporaneous to the clinical rotation and provided it to nursing instructors, who forwarded a complaint to the Facility and the Board.

29. On March 7, 2019, the Facility suspended Respondent from work. The Facility Administrator conducted a one-day investigation and determined that there was evidence Respondent was late or inconsistent in her medication rounds, but that there was insufficient evidence that Respondent was outside the one-hour time frame for administering medications. The Facility Administrator did not interview Ms. Copeland or Ms. Clark but concluded their other allegations were unfounded.

30. On March 11, 2019, the Facility gave Respondent a final written warning with stipulations as a condition of returning to work. The stipulations required Respondent to be monitored by another nurse at least twice weekly during medication passes and at least once per week during wound care for a period of a month. Respondent also was required to arrive with sufficient time before the start of her shift to take a report from the outgoing nurse, to notify certain personnel at any time she took a break or left the building, and to not take her break until her morning medication pass was completed.

31. Respondent successfully met the stipulations and continues to work at the Facility.

32. During the Facility Administrator's investigation, a patient said Respondent was stressed and gets sidetracked and was sometimes late with medication, but added that Respondent treated the patient well and was very caring. Another patient's daughter said Respondent would go "way beyond" and there was no reason to believe Respondent gave less than excellent care to her mother.

33. The Staff of the Board opened its own investigation of Respondent's conduct. On April 22, 2020, Staff sent Respondent a Notice of Hearing and First Amended Formal Charges (dated October 23, 2019). Together, these documents 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.

34. Administrative Law Judge (ALJ) Pratibha J. Shenoy convened the hearing via telephone on July 7, 2020. Assistant General Counsel Helen Kelley represented Staff, and Respondent represented herself. The record was held open to allow Respondent to submit certificates of completion for educational courses, but she made no submissions and the record was closed on July 17, 2020.

V. CONCLUSIONS OF LAW

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

2. The State Office of Administrative Hearings 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 is subject to sanction because she violated a Board order. Tex. Occ. Code § 301.452(b)(1), (10); 22 Tex. Admin. Code § 217.12(11)(B).

6. Respondent is subject to sanction because she committed unprofessional conduct and practiced below minimum standards of nursing care by conduct described in the Findings of Fact, including:

   a. failing to contemporaneously record administration of medication and back-dating medication records;

   b. administering metoprolol prior to assessing and/or recording pulse and blood pressure for two patients;

   c. failing to perform and/or document weekly skin assessment for a patient;

   d. failing to assess and/or document oxygen saturation for a patient;

   e. failing to follow proper infection control and medication administration techniques in opening pills into her hand instead of medication cups;

f. improperly disposing of medication in a trash can instead of in a biohazard container consistent with employer policy;

g. misappropriating Furosemide 20 mg tablet from one patient and administering it to another patient;

h. administering 8:00 a.m. and 12:00 p.m. medications at the same time to multiple patients;

i. administering scheduled medications to multiple patients two to three hours late;

j. documenting edema and pain levels before seeing and assessing the patient;

k. opening sterile wound care supplies without wearing gloves, cutting sterile gauze with scissors that had not been disinfected, and placing supplies on a surface that had not been sanitized; and

l. removing bandage on a wound prior to performing perineal care after a patient had a bowel movement, using a wipe that was already stained with feces to clean the wound, and using unsterile gauze to pack the wound.

This conduct is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(10) and (13), and 22 Texas Administrative Code §§ 217.11(1)(A), (B), (C), (D), (O), and (2), and 217.12(1)(A), (B), (C), (4), (6)(A), (G), and (H), (10)(C), and (11)(B).

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

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

9. The Board may consider as aggravating factors the number of violations; Respondent's prior Board Orders; disciplinary action by Respondent's employer for conduct similar to that at issue in this case; and patient vulnerability. 22 Tex. Admin. Code § 213.33(b)-(c).

10. The Board may consider as mitigating factors the lack of evidence of serious harm to patients; positive comments provided by patients regarding Respondent's practice, even when the patients also acknowledged Respondent's shortcomings; the fact that Respondent has practiced since 2009; Respondent's successful completion of the stipulations imposed by the Facility when she returned to work in March 2019; and her subsequent practice without any known complaints. 22 Tex. Admin. Code § 213.33(b)-(c).

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue a two-year Order with a Reprimand and stipulations including: completion of classes in medication administration, jurisprudence, documentation, critical thinking, and other subjects the Board deems proper; a requirement that Respondent provide a copy of the Order and Reprimand to her employer and cause the employer to send quarterly performance reviews to the Board; and mandating that Respondent complete one year of work with direct supervision, followed by one year of work with indirect supervision, with a prohibition on critical care positions and night shifts for the first year.

SIGNED September 11, 2020.

Pratibha J. Shenoy

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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.

Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED
Vocational Nurse License Number 220738	§	
issued to JESSICA JAYNE HARDMAN	§	
A.K.A. JESSICA HARDMAN COZART	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JESSICA JAYNE HARDMAN, Vocational Nurse License Number 220738, 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), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on January 2, 2017.

FINDINGS OF FACT

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

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

3. Respondent's license to practice as a vocational nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from Texas State Technical College, Sweetwater, Texas, on December 13, 2008. Respondent was licensed to practice vocational nursing in the State of Texas on February 24, 2009.

5. Respondent's nursing employment history includes:

2/2009-7/2013	Licenced Vocational Nurse	Stephens Memorial Hospital Breckenridge, Texas

Respondent's nursing employment history continued:

8/2013-8/2014	Licensed Vocational Nurse	Snyder Oaks Snyder, Texas
11/2014-7/2015	Licensed Vocational Nurse	Cedar Crest Breckenridge, Texas
7/2015-9/2015	Licensed Vocational Nurse	Tri-Star Home Health Breckenridge, Texas
9/2015-11/2015	Licenced Vocational Nurse	Cisco Nursing Home Cisco, Texas
11/2015-3/2016	Licenced Vocational Nurse	Villa Haven Health and Rehabilitation Center Breckenridge, Texas
4/2016-2/2017	Unknown	
3/2017-Present	Licensed Vocational Nurse	Angels of Care Abilene, Texas

6. On or about December 1, 2015, Respondent's license to practice nursing in the State of Texas were issued the sanction of REMEDIAL EDUCATION WITH A FINE through an Agreed Order by the Board. Respondent has not successfully completed the terms of this Order. A copy of the Agreed Order, including the Findings of Fact, Conclusions of Law, and Order dated December 1, 2015, is attached and incorporated by reference as part of this Order.

7. At the time of the initial incident, Respondent was employed as a Licenced Vocational Nurse with Villa Haven Health and Rehabilitation Center, Breckenridge, Texas, and had been in that position for four (4) months.

8. On or about March 26, 2016, while employed as a Licensed Vocational Nurse with Villa Haven Health and Rehabilitation Center, Breckenridge, Texas, Respondent misappropriated a resident's medication from the medication cart, and dispensed the medication to a certified nurse aide (CNA), who had complaints of nausea. Respondent's conduct was likely to defraud the patient and/or the facility of the cost of the medication, and providing medication without a physician's order could result in the patient suffering from adverse reactions.

9. On or about March 26, 2016, through March 28, 2016, while employed as a Licensed Vocational Nurse with Villa Haven Health and Rehabilitation Center, Breckenridge, Texas, Respondent signed out Norco, Tylenol #3, Tramadol, Lyrica, Clonazepam, and Fiorcet, on

the Individual Controlled Drug Record for eight (8) patients, but failed to document the administration of the medications in the residents' Medication Administration Records and/or Nurse's Notes. Respondent's conduct was likely to injure the residents in that subsequent care givers would rely on her documentation to provide further care and medicate the patients, which could result in an overdose. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

10. On or about March 26, 2016, through March 28, 2016, while employed as a Licensed Vocational Nurse with Villa Haven Health and Rehabilitation Center, Breckenridge, Texas, Respondent failed to administer and/or document administration of medication to twenty-three (23) residents. Respondent's conduct created an incomplete medical record and failure to administer medications as ordered by the physician could result in non-efficacious treatment.

11. In response to the incident in Finding of Fact Number Eight (8), Respondent states that she was passing medications when a CNA came up to her with a complaint of nausea and vomiting, which was not surprising because they had about twenty (20) residents at the time with nausea and vomiting. Respondent states that she asked the CNA what she could take over the counter, and she decided on Zantac. Respondent states she gave her the medication and thought it was in the residents' and staff's best interest since they were short staffed with no relief in sight.

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) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(4),(6)(G)&(11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 220738, heretofore issued to JESSICA JAYNE HARDMAN.

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

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

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

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

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

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

II. COMPLIANCE WITH LAW

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

III. REMEDIAL EDUCATION COURSE(S)

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

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study courses and video programs will not be approved.

B. **A Board-approved course in medication administration** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components be provided by the same Registered Nurse. The course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the six (6) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The clinical component SHALL focus on tasks of medication administration only. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

C. **A Board-approved course in 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.

D. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

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

IV. MONETARY FINE

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

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) quarterly periods of employment as a nurse have elapsed. Any quarterly period without continuous employment with the same employer for all three (3) months will not count towards completion of this requirement. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

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

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

C. **Incident Reporting:** While employed as a Licenced Vocational Nurse with Angels of Care, Abilene, Texas, RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

D. **Indirect Supervision:** Should Respondent's employment as a Licenced Vocational Nurse with Angels of Care, Abilene, Texas, cease or change, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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

VI. SUPERCEDING ORDER

IT IS FURTHER AGREED and ORDERED that the sanction and conditions of this Order SHALL supercede all previous stipulations required by any Order entered by the Texas Board of Nursing.

VII. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed

from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT may be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

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

Signed this 23rd day of October, 2017.

Jessica Jayne Hardman

JESSICA JAYNE HARDMAN, Respondent

Sworn to and subscribed before me this 23rd day of October, 2017.

SEAL ANDREA MAY NOTARY PUBLIC STATE OF TEXAS My Comm. Expires 09-17-2018

Andrea May

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 23rd day of October, 2017, by JESSICA JAYNE HARDMAN, Vocational Nurse License Number 220738, and said Order is final.

Effective this 12th day of December, 2017.

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

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED
Vocational Nurse License Number 220738	§	
issued to JESSICA JAYNE HARDMAN	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boar considered the matter of JESSICA JAYNE HARDMAN, Vocational Nurse License Number 220738, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(2)&(10), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on October 20, 2015.

FINDINGS OF FACT

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

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

3. Respondent's license to practice as a vocational nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from Texas State Technical College West Texas, Sweetwater, Texas, on December 13, 2008. Respondent was licensed to practice vocational nursing in the State of Texas on February 24, 2009.

5. Respondent's nursing employment history includes:

02/2009 - 07/2013	LVN	Stephens Memorial Hospital Breckenridge, TX

(nursing employment history continued)

08/2013 - 08/2014	Charge Nurse	Snyder Oaks Snyder, TX
08/2014 - 11/2014	Unknown	
11/2014 - 07/2015	Charge Nurse	Cedar Crest Breckenridge, TX
07/2015 - 09/2015	Staff Nurse	Tri-Star Home Health Cisco, TX
09/2015 - Present	Charge Nurse	Cisco Nursing and Rehab Cisco, TX

6. On or about August 28, 2013, Respondent submitted an Online Renewal Document to the Texas Board of Nursing in which she provided false, deceptive, and/or misleading information, in that she answered "No" to the question: "Have you, within the past 24 months or since your last renewal, for any criminal offense, including those pending appeal:
   A. been convicted of a misdemeanor?
   B. been convicted of a felony?
   C. pled nolo contendere, no contest, or guilty?
   D. received deferred adjudication?
   E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
   F. been sentenced to serve jail or prison time? court-ordered confinement?
   G. been granted pre-trial diversion?
   H. been arrested or have any pending criminal charges?
   I. been cited or charged with any violation of the law?
   J. been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?"

   Respondent failed to disclose that, on or about November 29, 2012, Respondent entered a plea of Guilty to and was convicted of OBSTRUCTING HIGHWAY PASSAGEWAY, a Class B misdemeanor offense, in the County Court, Robertson County, Texas, under Cause No. 12-538-CR. As a result of the conviction, Respondent was sentenced to confinement in the Robertson County Jail for a period of two (2) days with credit given.

7. On or about August 27, 2015, Respondent submitted an Online Renewal Document to the Texas Board of Nursing in which she provided false, deceptive, and/or misleading information, in that she answered "No" to the question: "Have you, within the past 24 months or since your last renewal, for any criminal offense, including those pending appeal:

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

Respondent failed to disclose that, on or about March 17, 2015, Respondent was arrested by the Eastland County Sheriff's Office, Eastland, Texas, for THEFT PROP>=$20<$500 BY CHECK, a Class B misdemeanor offense. Respondent was subsequently charged under Cause No. 56668 for THEFT PROP >=$20<$500 BY CHECK. The charge was pending at the time of renewal.

CONCLUSIONS OF LAW

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

2. Notice was served in accordance with law.

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

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(2)&(10), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 220738, heretofore issued to JESSICA JAYNE HARDMAN.

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, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of **REMEDIAL EDUCATION WITH A FINE** in accordance with the terms of this Order.

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

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

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

II. COMPLIANCE WITH LAW

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

III. REMEDIAL EDUCATION COURSE(S)

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

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study courses and video programs will not be approved.

B. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

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

IV. MONETARY FINE

RESPONDENT SHALL **pay a monetary fine in the amount of seven hundred fifty dollars ($750.00) within forty-five (45) days of entry of this Order.** Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT may be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

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

Signed this 20 day of November, 2015.

JESSICA JAYNE HARDMAN, Respondent

Sworn to and subscribed before me this 20 day of November, 2015.

SEAL
BARBARA SEATON
Notary Public
STATE OF TEXAS
My Comm. Exp. July 19, 2017

Notary Public in and for the State of 7-19-17

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 20th day of November, 20 15, by JESSICA JAYNE HARDMAN, Vocational Nurse License Number 220738, and said Order is final.

Effective this 1st day of December, 20 15.

Katherine A. Thomas

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