BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse License Number 779320 issued to WINIFRED RENEE POWERS	§ § § § §	AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, consi the matter of WINIFRED RENEE POWERS, Registered Nurse License Number 779320, 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)(8), 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 November 3, 2025.

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 professional nurse in the State of Texas is in current status.

4. Respondent received an Associate Degree in Nursing from Central Texas College, Killeen, Texas, on December 18, 2009. Respondent was licensed to practice professional nursing in the State of Texas on January 19, 2010.

5. Respondent's nursing employment history includes:

1/2010 – 5/2012	Unknown	
6/2012 – 6/2016	RN	Lighthouse Nursing, Inc. Killeen, Texas

Respondent's nursing employment history continued:

6/2016 – 3/2020	RN	Baylor Scott & White Health Temple, Texas
4/2020 – 9/2022	Unknown	
10/2022 – 12/2022	Travel/Contract RN	Aya Healthcare – University of New Mexico Hospital, Albuquerque, New Mexico
1/2023 – 2/2023	Unknown	
3/2023 – Unknown	RN	Interim Home Health & Hospice Temple, Texas
Present	RN	Canyon Creek Behavioral Health Temple, Texas

6. On or about January 4, 2021, Respondent was issued the sanction of Remedial Education through an Order of the Board. On or about October 5, 2021, Respondent successfully completed the terms of the Order. A copy of the January 4, 2021, Order is attached and incorporated herein, by reference, as part of this Agreed Order.

7. On or about February 12, 2025, Respondent was issued a Final Decision and Order by the Board of Nursing for the State of New Mexico, Albuquerque, New Mexico, which revoked her privilege to practice from the State of Texas. A copy of the New Mexico Final Decision and Order, dated February 12, 2025, is attached and incorporated herein, by reference, as part of this Order.

8. In response to Finding of Fact Number Seven (7), Respondent states that she was in New Mexico as a travel nurse in an extremely busy Emergency Room with insufficient staffing, turnover was extremely high, and physician conduct was erratic. Respondent states that the doctors at that facility would put in medication orders, then change them orally at the bedside. Respondent admits she pulled medications but states she wasted them if they were not administered. Respondent states in January 2023, she was notified by the New Mexico Nursing Board that a complaint was filed. Respondent further states she tried to find an attorney to represent her at the merit hearing, but she was unsuccessful.

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 cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 779320, heretofore issued to WINIFRED RENEE POWERS.

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

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

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

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

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

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

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

II. COMPLIANCE WITH LAW

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

III. 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.

IV. 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.

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. **The course "Righting a Wrong,"** a 3.0 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).

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.*

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. 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. **Indirect Supervision:** 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.

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

VI. 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.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

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

Signed this 27 day of November, 2025.

WINIFRED RENEE POWERS, RESPONDENT

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

SEAL

_____

Notary Public in and for the State of _____

Approved as to form and substance.

Deborah Goodall, Attorney for Respondent

Signed this 30th day of November, 2025.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 27th day of November, 2025, by WINIFRED RENEE POWERS, Registered Nurse License Number 779320, and said Agreed Order is final.

Effective this 22nd day of January, 2026.

Kristin K. Benton, DNP, RN

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

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse License Number 779320 issued to WINIFRED RENEE POWERS	§ § § §	AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of WINIFRED RENEE POWERS, Registered Nurse License Number 779320, 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 Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on October 7, 2020.

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 professional nurse in the State of Texas is in current status.

4. Respondent received an Associate Degree in Nursing from Central Texas College, Killeen, Texas, on December 18, 2009, and a Bachelor Degree in Nursing from the University of Texas at Arlington, Arlington, Texas, on December 16, 2017. Respondent was licensed to practice professional nursing in the State of Texas on January 19, 2010.

5. Respondent's nursing employment history includes:

1/2010 – 5/2012	Unknown

Respondent's nursing employment history continued:

6/2012 – 6/2016	RN	Lighthouse Nursing, Inc. Killeen, Texas
6/2016 – 3/2020	RN	Baylor Scott & White Health Temple, Texas
4/2020 – Present	Unknown	

6. At the time of the incident, Respondent was employed as a Registered Nurse with Baylor Scott & White Health, Temple, Texas, and had been in that position for thee (3) years and eight (8) months.

7. On or about February 13, 2020, through February 19, 2020, while employed as a Registered Nurse with Baylor Scott & White Health, Temple, Texas, Respondent withdrew medications from the medication dispensing system for Patients 1224969, 0493912, 0980633, 4965600, 841122 and 0672645 and failed to appropriately document the pain assessments in the patients' medical records. Respondent's conduct was likely to injure the patients from clinical care decisions formulated based upon incomplete assessment information.

8. In response to Finding of Fact Number Seven (7), Respondent states she failed to document the assessments; however, her common practice throughout her nursing career has been to document patients' pain assessments according to the proper rules. Respondent relates she asked the facility for remediation, but was denied.

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)(D), and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 779320, heretofore issued to WINIFRED RENEE POWERS.

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 **REMEDIAL EDUCATION** 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. 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. 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.

IV. REMEDIAL EDUCATION COURSE(S)

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

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

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

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

V. 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.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

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 becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary 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 29 day of Dec, 2020.

WINIFRED RENEE POWERS, RESPONDENT

Sworn to and subscribed before me this 29 day of Dec., 20 20.

SEAL

OSCAR SERNA, JR
My Notary ID # 132051688
Expires June 14, 2023

Notary Public in and for the State of Texas

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 29th day of December, 2020, by WINIFRED RENEE POWERS, Registered Nurse License Number 779320, and said Agreed Order is final.

Effective this 4th day of January, 2021.

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

EFORE THE BOARD OF NURSING
FOR THE STATE OF NEW MEXICO

IN THE MATTER OF:

Case No. 2022120036

WINIFRED POWERS,
License No. 779320 (RN) PTP-TX

Respondent.

FINAL DECISION AND ORDER

THIS MATTER came before a quorum of the Board of Nursing (hereinafter the "Board") at an open public meeting held on January 16, 2025, upon a complaint filed against Winifred Powers ("Respondent") alleging possible violations of the New Mexico Nursing Practice Act, NMSA 1978, Sections 61-3-1 to -30 (1968, as amended through 2019) (the "Act"). A formal evidentiary hearing in this matter was held on December 5, 2024, and presided over by designated Hearing Officer and Administrative Law Judge Ignacio V. Gallegos, pursuant to the Uniform Licensing Act, NMSA 1978, Sections 61-1-1 through -35 (1957, as amended through 2020) (the "ULA"), the Act, and the Board's rules. The Board, having familiarized itself with the whole record, including the Hearing Officer's Report, voted to adopt the Hearing Officer's Proposed Findings of Fact and find Respondent to have violated the Act and the Board's rules, and issue disciplinary sanctions of revocation of her license, and a fine of $2,500 to be paid within one hundred twenty (120) days of receipt of this Order. The Board hereby issues the following:

FINDINGS OF FACT

The Board hereby adopts the Hearing Officer's Proposed Findings of Fact, numbered 1 through 34, and incorporates them into their Final Decision and Order as stated herein.

CONCLUSIONS OF LAW

1. Respondent is subject to the jurisdiction of the Board.
2. Pursuant to Section 61-1-3, Section 61-3-28, and 16.12.12.12 NMAC, the Board held an evidentiary hearing on this matter on December 5, 2024, and previously provided Respondent with proper notice of the general nature of the allegations and evidence against her.
3. Respondent was provided timely notice of the hearing and advised of her rights.
4. The Board has complied with all notice and other procedural and due process requirements of the Act, the ULA, and the Board's rules.
5. Section 61-3-28(A) of the Act states that the Board may discipline a licensee, up to and including suspension or revocation, on finding that the licensee "is guilty of unprofessional conduct as defined by the rules and regulations adopted by the Board[.]" Section 61-3-28(A)(6).
6. The Board's rules define "unprofessional conduct" as inclusive of, but not limited to, "Misconduct involving other procedures or policies, such as…failure to follow established procedure and documentation regarding controlled substances." 16.12.12.9(F).
7. Based on the testimony and evidence introduced at the evidentiary hearing in this case, a preponderance of the evidence supported the allegations in the Notice of Contemplated Action ("NCA") and the finding that Respondent engaged in unprofessional conduct as defined by the Board's rules.
    a. The testimony of multiple witnesses, as well as multiple exhibits of evidence, showed by preponderance of the evidence that Respondent did engage in excessive medication waste, including of narcotics, against the policies of the hospital where she worked.

8. The Board finds that Respondent is guilty of unprofessional conduct in violation of Section 61-3-28(A)(6).

9. It is the duty of the Board to enforce the Act and the Board's rules as part of its mission to "promote, preserve and protect the public health, safety and welfare." Section 61-3-2.

10. Respondent's conduct warrants the imposition of discipline.

ORDER

Based on these Findings of Fact and Conclusions of Law, a quorum of the Board voted to adopt the Findings of Fact set forth in the Hearing Officer's report, find Respondent to have violated the Act and the Board's rules, and issue a disciplinary sanction to Respondent in the form of a revocation of her license, and a fine of $2,500 to cover the cost of the prosecution.

IT IS THEREFORE ORDERED that Respondent shall pay the Board a fine in the amount of $2,500 within one hundred twenty (120) days of receipt of this Order.

IT IS FURTHER ORDERED that Respondent's license shall be revoked. This Order constitutes formal disciplinary action by the Board and may be reported to the applicable professional licensing national database, if any.

IT IS FURTHER ORDERED that failure on the part of Respondent to fulfill the above sanctions as ordered herein shall result in further Board action. Any such violation shall result in the immediate and automatic filing of an administrative Notice of Non-Compliance by the Board's Executive Director. Upon the filing of a Notice of Non-Compliance, the matter shall be scheduled for the next public meeting of the Board, at which time the Board shall hear from Board staff regarding the alleged non-compliance. Respondent shall have the opportunity to address the allegations or offer any other relevant argument or evidence regarding the reasons for non-compliance. Such argument or evidence may be provided in writing prior to the meeting or in person at the Board meeting. Any presentation regarding the Notice of Non-Compliance shall be limited to evidence surrounding Respondent's alleged failure to comply with the Agreement. The Board may also initiate a new disciplinary action and refer that matter for administrative prosecution.

IT IS SO ORDERED.

/s/ Jacqueline Kaiser 02-12-2025
Jacqueline Kaiser, Chair Date
New Mexico Board of Nursing

JUDICIAL REVIEW

This Order constitutes a final decision for purposes of initiating any contemplated judicial review pursuant to the provisions of the Uniform Licensing Act, NMSA 1978, Section 61-1-17, and NMSA 1978, Section 39-3-1.1. An aggrieved party has the right to judicial review of this Order by filing a notice of appeal under Rule 1-074 NMRA within thirty (30) days of the date of filing of the final decision. Any pleadings filed with the district court must be served on the Board's counsel, Assistant Attorney General Douglas Wilber, at 201 3rd St NW Suite 300, Albuquerque, NM 87102 dwilber@nmdoj.gov.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was mailed by certified mail and emailed to Respondent on this 12th day of February 2025, as listed below:

Winifred Powers
[redacted]

/s/ Melanie Segura
Melanie Segura, Paralegal for NM BON
Melanie.segura@bon.nm.gov

CERTIFIED MAIL NO. 9589 0710 5270 1039 2038 58
RETURN RECEIPT REQUESTED

Mission: Protect the public safety through effective regulation of nursing care and services

FORMAL DISCIPLINARY DOCUMENT

I do hereby certify this is a complete, true, and accurate copy of the document on file with the New Mexico Board of Nursing.

Sheena M. Ferguson, DNP, MSN, RN ANAI
Executive Director
New Mexico Board of Nursing

STATE OF NEW MEXICO
ADMINISTRATIVE HEARINGS OFFICE

STATE OF NEW MEXICO
BOARD OF NURSING (BON)
v.
WINIFRED POWERS
License Number: RN-779320
(Respondent)

Case No. 2022120036

HEARING OFFICER'S REPORT
AND RECOMMENDATION OF DISCIPLINE

On December 5, 2024, a videoconference hearing on the merits of the Board of Nursing's (BON's) Notice of Contemplated Action against Winifred Powers, RN # 779320 (Respondent) was held by Hearing Officer Ignacio V. Gallegos, Esq. Attorney Christopher Sturgess appeared at the hearing on behalf of the Board of Nursing (BON). The Respondent, Winifred Powers, appeared at the hearing representing herself. The Hearing Officer preserved an audio recording of the hearing. All parties, witnesses, and the Hearing Officer participated by Zoom videoconferencing.

The BON presented the testimony of two witnesses: 1) Marian Lyons-Ordoñez, University of New Mexico Hospital Med Pyxis System Administrator; and 2) Cynthia Tagg, NM BON Investigator. Respondent Winifred Powers testified on her own behalf. All witnesses were subject to cross examination by the opposing party. Exhibits A, B, C, D, E, and F were admitted by stipulation of the parties.

In short summary, this matter concerns an accusation alleging "unprofessional conduct" against Respondent for the excessive waste of medications. Respondent admitted to the fact that she withdrew medications without written orders, but Respondent attributed the waste to doctors in a busy emergency room who gave verbal orders then either changed the order when written or failed to provide the written orders. The Hearing Officer finds that the evidence that Respondent

wasted medications is substantial and uncontroverted. The Hearing Officer finds that despite the Respondent's attribution to others' errors, the waste was not justified. Respondent was otherwise credible. More credible on the crucial issue of the issuance of verbal orders for narcotics, was the BON's witness Cynthia Tagg. Further, Respondent minimized the potential harm of her unprofessional conduct.

Based on the evidence in the record, and after making findings of fact detailed below, the Hearing Officer finds in favor of the BON's contention that Respondent has committed "unprofessional conduct" in violation of NMSA 1978, Section 61-3-28 (A)(6), as well as Regulation 16.12.12.9 (F) NMAC, and Regulation 16.12.12.7 (J) NMAC. Therefore, the Hearing Officer's recommends that the BON suspend Respondent's professional license, with probation to include daily drug and alcohol testing, counseling, and completion of the diversion program.

FINDINGS OF FACT

Procedural findings

1. On October 2, 2024, the BON issued and sent a Notice of Contemplated Action (NCA) to the Respondent Winifred Powers by certified mail return receipt requested (#7022 0410 0002 0004 9728) and by email. [Administrative file].

2. On October 8, 2024, the BON received the Respondent's letter requesting a formal hearing concerning the Notice of Contemplated Action. [Administrative file].

3. On October 10, 2024, the BON filed the NCA, the BON's transmittal memo, the Respondent's request for hearing, and the BON's hearing request with the Administrative Hearings Office (AHO). [Administrative file].

4. On October 15, 2024, the BON filed a corrected hearing request with the Administrative Hearings Office (AHO). [Administrative file].

5. On October 17, 2024, the undersigned Hearing Officer issued a Notice of Videoconference Scheduling Hearing and Notice of Videoconference Merits Hearing to the parties at the addresses and email addresses listed in the BON's hearing request. The notice was sent to the Respondent by certified mail, return receipt requested (# 7022 2410 0002 2915 9532) as well as email. [Administrative file].

6. On November 6, 2024, the Hearing Officer conducted a video conference scheduling conference. Attorney Christopher Sturgess appeared on behalf of the BON, by video conference. Respondent appeared by video conference. The Hearing Officer preserved an audio recording of the scheduling conference. [Administrative file].

7. On November 13, 2024, the BON filed its Witness and Exhibit List. [Administrative file].

8. On December 5, 2024, the BON filed its final Witness and Exhibit List. [Administrative file].

9. The Hearing Officer conducted the hearing on the merits of the Notice of Contemplated Action on December 5, 2024. Evidence in the form of testimony and exhibits were accepted into the record. The Hearing Officer preserved an audio record of the hearing. [Administrative file].

Substantive Findings

10. Respondent Winifred Powers is a registered nurse, licensed in Texas. Respondent's nursing license number is 779320. [Administrative file].

Case Number 2022120036.

11. Respondent was employed at University of New Mexico Hospital, located in Albuquerque, New Mexico. Respondent was a travelling nurse and worked primarily in the

emergency room for a thirteen-week contract from October through early December of 2022. [Examination of W. Powers; Examination of M. Ordoñez; Examination of C. Tagg; Exhibit A].

12. A nurse's ordinary work week at the emergency room consists of three twelve-hour days. Respondent was offered overtime and worked overtime during her contract. [Examination of C. Tagg; Examination of W. Powers; Exhibit B-2].

13. As part of the onboarding process for travelling nurses, Respondent's records show she completed training in hospital protocols and policies, including charting medications and Pyxis training. In addition, Respondent completed eleven online modules, four of which were Pyxis-based trainings, including medication inventory control, resolving discrepancies, and how to waste medication. [Examination of C. Tagg].

14. Ms. Ordoñez is the Med Pyxis system administrator for the University of New Mexico Hospital and held this position at the time of the audit in 2022. [Examination of M. Ordoñez].

15. Emergency room nurses use the Med Pyxis system for dispensation of medications. The system tracks the date and time the medication was dispensed, the FIN patient numbers for billing, the medication name, the dosage, the actions, and other details. The system flags instances in which medications are dispensed but not administered, returned, or wasted. [Examination of M. Ordoñez; Exhibit D].

16. The Med Pyxis system has an automated audit system that looks at dispensing trends, particularly with controlled substances. During the first few weeks Respondent worked at the University of New Mexico Hospital, the system flagged a variance of withdrawal of medications without documentation. The system conducted an audit of Respondent's handling of the Pyxis. The hospital staff was alerted to the variance for the audit of Ms. Powers'

utilization of the Med Pyxis system for the period of November 6, 2022, through December 2, 2022, citing excessive whole package waste. [Examination of M. Ordoñez; Exhibit D].

17. The Med Pyxis system issues a billing code to the finance department when a medication is removed from the system under the patient's account number and the medication is not returned intact to the system. [Examination of M. Ordoñez; Exhibit D].

18. The Med Pyxis system allows medications to be returned intact so that they are not wasted. In this instance, the system provides a refund to the patient for the billing. [Examination of M. Ordoñez; Exhibit D].

19. The Med Pyxis System records a medication as waste when a medication is removed from the Pyxis but not administered to a patient and not returned intact. [Examination of M. Ordoñez; Exhibit D].

20. Under the Medications Orders and Administration Policy, the transactions noted as "waste", were considered instances of acting outside the scope of employment, position, or certification, because the withdrawal of the medications was not following a provider's order. [Examination of M. Ordoñez; Exhibit D].

21. The audit report shows "does not match MAR" for each of the lines highlighted in red. The MAR refers to Medication Administration Report. During the roughly one-month period covered by the audit, there are 74 lines highlighted in red. The highlighted portions show a line for the withdrawal, and a line to report either waste or a return. [Examination of C. Tagg; Exhibit D].

22. The medications withdrawn and not administered to patients were: Hydromorphone (Dilaudid), 33 instances; Fentanyl, 5 instances; and Morphine, 3 instances. Each of these are opioids and controlled substances. [Examination of C. Tagg; Exhibit C; Exhibit D].

23. The automated audit concluded that there was a suspicion of medication diversion. [Examination of M. Ordoñez; Exhibit A].

24. After receiving the audit, Ms. Ordoñez contacted hospital leadership, who investigated records and patterns, and agreed with the determination that Respondent posed a high risk. [Examination of M. Ordoñez; Exhibit C].

25. As a result of the audit and subsequent review by hospital administrators, the contract with Respondent was terminated through her staffing agency, Aya Healthcare. [Examination of M. Ordoñez; Examination of C. Tagg; Exhibit B].

26. Ms. Ordoñez reported the improper handling of controlled substances on December 14, 2022, to the Board of Nursing, the Drug Enforcement Administration, and to the New Mexico Board of Pharmacy. [Examination of M. Ordoñez; Exhibit C].

27. Respondent testified that the emergency room was large, serving a large radius as the only trauma center, and the most chaotic and unsafe place she had ever worked. [Examination of W. Powers].

28. Respondent testified that her practice was to withdraw the medication on a doctor's verbal order, open the package, and prepare the medication for administration. At times, she would get to the patient's bedside and the medication had already been given. At other times, she would get to the patient's bedside, and the medication order would be different. [Examination of W. Powers].

29. Ms. Tapp is a former nurse, retired after 40 years as a nurse, with extensive experience in practice and administration, who is the investigator for the Board of Nursing. Ms. Tapp testified that it is very unusual for doctors, even in a busy emergency room, to give verbal orders for narcotics. In her experience, doctors will give verbal orders, and attending

physicians will sometimes change the order of a resident, however, verbal orders for medications are rare and not generally for narcotics. [Examination of C. Tagg].

30. As an example of the practice of a doctor giving a verbal order then changing it, Respondent pointed to three lines of the audit (Exhibit D-2), concerning patient number 357726439. Respondent testified that 11:30 P.M., the doctor gave a verbal order for hydromorphone, which she pulled out and readied for administration. When she looked at the written order on the MAR, the order had changed to morphine, so she had to waste the hydromorphone at 11:35 P.M., and then pulled and administered morphine at 11:36 P.M. [Examination of W. Powers].

31. Respondent testified that a doctor would give a verbal order and then decide not to administer a pain medication. As an example of the practice, Respondent pointed to another section of the audit (Exhibit D-4-D-5), concerning patient number 357520345. Respondent testified that she wasted dilaudid (hydromorphone) when the doctor gave a verbal order then decided not to administer a pain medication. She pulled the medicine at 19:14 hours, and, after an hour and a half trying to get ahold of the doctor, then when he responded he said he did not want to administer the medicine to this patient, so she wasted it at 20:44 hours. Respondent said this happened twice. [Examination of W. Powers].

32. As a second example of the practice of a doctor giving a verbal order then changing it, Respondent pointed to the audit (Exhibit D-5), concerning patient number 357520774. Respondent testified that she was given a verbal order for fentanyl and Respondent pulled it from the Pyxis at 2:16 hours. The doctor then changed the prescription to hydromorphone verbally, so she had to waste the fentanyl at 2:33 hours. She then withdrew hydromorphone at 3:56 hours, and the doctor changed the prescription a second time to oxycodone, so she wasted

the hydromorphone at 4:12 hours. Oxycodone was administered at 4:34 hours. Respondent testified that this happened all the time. [Examination of W. Powers; Exhibit D-5].

33. As another example of the practice of a doctor giving a verbal order then changing it, Respondent pointed to the audit (Exhibit D-5and D-6), concerning patient number 357499920. Respondent testified that she was given a verbal order for fentanyl and Respondent pulled it from the Pyxis at 19:39 hours on November 20, 2022. The total fentanyl was wasted at 19:48 hours on November 20, 2022. Again, Respondent testified that the doctor changed the prescription for this patient to hydromorphone at 19:49 hours, so at that time she pulled the hydromorphone from the Pyxis, followed by a waste at 20:58 hours. Oxycodone was pulled and administered to the patient at 20:17 hours. Another verbal order, Respondent testified, was given at 22:19 hours, and that was wasted at 21:44 hours. Another verbal order, Respondent testified, was given at 23:00 hours, and that was wasted at 23:24 hours. Another order was given at 00:53 hours of the following day, November 21, 2022, and that was wasted at 2:04 hours. And at 2:44 hours of November 21, 2022, the doctor gave a written order for oxycodone, and that was administered. [Examination of W. Powers; Exhibit D-5 and D-6].

34. Both Ms. Tagg and Respondent agreed that the patient medical records not in evidence would be the best evidence of what occurred with each patient. [Examination of W. Powers; Examination of C. Tagg].

35. Both Ms. Tagg and Ms. Ordoñez testified that the practice of excessive waste was contrary to the practices established under human resources policies HR 130[1] and HR 130, 8C. [Examination of M. Ordoñez; Examination of C. Tagg].

---

[1] HR policy 130 is available online at (last visited 12/30/24).

36. Mishandling and excessive waste is contrary to HR policy 130 "Acting outside of the scope of employment, position, or professional license" which prohibits pulling medications without a provider order, particularly HR policy 130, #8C, referring to mishandling of controlled substances. [Examination of C. Tagg].

37. Respondent testified that if someone viewed the video recordings from the hospital camera system, she could be seen taking medications out from the Pyxis and then going to the bathroom. Respondent explained this was on account of her colitis, and its symptom of needing to use the restroom frequently. [Examination of W. Powers].

38. Respondent acknowledged that pulling medications without a corresponding doctor's order is outside the scope of nursing practice. [Examination of W. Powers; Examination of C. Tagg].

Aggravating and mitigating factors.

39. There was an implication, but no fact on record that the Respondent was using the medications herself to support a drug addiction.

40. Respondent testified that she was suffering from colitis during the time at issue, which required frequent trips to the restroom.

41. Respondent's demeanor was composed and more credible than not.

42. Respondent has a history of discipline from the State of Texas for failure to document pain assessments before withdrawing pain medications. And as a result, Respondent was required to take remedial courses in the areas of nursing jurisprudence and ethics, nursing documentation, and sharpening critical thinking skills.

43. Respondent did not seem to accept the gravity of the medication waste, since patients were billed for the medications removed in their name, but not administered to them, and not returned intact.

DISCUSSION

The Notice of Contemplated Action filed by the BON, alleges that Respondent violated the Nursing Practice Act, by being guilty of unprofessional conduct, a violation of Section 61-3-28 (A)(6) and Rule 16.12.12.9 (F). The rules governing nursing provide a definition of unprofessional conduct as "any departure from or failure to conform to the minimal standards of acceptable and prevailing nursing practice, including but not limited to such conduct which is or may be harmful to the health, safety, or welfare of the public or which reflects negatively on the individual's fitness to practice nursing or on the profession more broadly." Regulation 16.12.12.7 (J) NMAC. As examples of unprofessional conduct, the regulation specifically cites misconduct by "failure to follow established procedure and documentation regarding controlled substances" Regulation 16.12.12.7 (J) (5) (b).

The record is clear and uncontroverted that (1) hydromorphone (dilaudid) is a narcotic, a controlled substance; (2) fentanyl is a narcotic, a controlled substance; and (3) oxycodone is a narcotic, a controlled substance. The record is also clear that on 33 instances during the roughly one-month audit period, Respondent withdrew and did not administer dilaudid. The record is clear that on five instances, Respondent withdrew and did not administer fentanyl.

The hospital policies Respondent allegedly violated were not placed in the record, but are available to the public online. Policy #HR 130, #8C prohibits "Misuse or mishandling of any controlled substance, such as pulling drugs but not administering them or not knowing the subsequent whereabouts of the drugs." Both Respondent and BON witnesses agreed that to

withdraw a medication without a doctor's order would be a violation of nursing practice. Respondent Winifred Powers withdrew medications – controlled substances – without written orders given by a doctor. In doing so, Respondent engaged in unprofessional conduct by "failure to follow established procedure and documentation regarding controlled substances" Regulation 16.12.12.7 (J) (5) (b).

At administrative hearings, credibility is a key factor. "It is the sole responsibility of the trier of fact to weigh the testimony, determine the credibility of the witnesses, reconcile inconsistencies, and determine where the truth lies." *N.M. Taxation & Revenue Dep't v. Casias Trucking*, 2014-NMCA-099, ¶ 23, 336 P.3d 436. The Respondent did not deny the allegation of waste and accepted some degree of responsibility for her actions, indicating that she knew the practice was unsafe and has changed her practice now. Respondent provided an explanation of her behavior and cast blame on doctors for giving verbal orders and then changing the order. While a doctor giving verbal orders is not unheard of, the sheer number of alleged verbal orders casts significant doubt on the testimony of the Respondent.

For example, concerning patient # 357499920 (FOF#33), taking the Respondent's testimony and the audit report at face value, a doctor gave verbal orders four times for dilaudid and once for fentanyl, only to cancel the orders, within the approximately seven-hour visit, that records show was between November 20, 2022, at 19:39 hours and 2:44 hours on the following day. The only pain medication administered to this patient was oxycodone, following the MAR, once at 20:17 and once at 2:44 hours on the following day. It is extremely implausible that a doctor would give five verbal orders for the same patient only to cancel them and order the same medication twice in written form. What is more likely is that the Respondent provided a window

into her methodology of removing controlled substances without doctor's orders. The evidence presented a clear violation of Regulation 16.12.12.7 (J) NMAC.

Recommendation of discipline.

Under the Uniform Licensing Act, after the hearing, the hearing officer shall submit to the board a report setting forth the hearing officer's findings and recommendations. NMSA 1978, Section 61-1-7 (A) (2023). The Board of Nursing may then opt to adopt or reject the hearing officer's recommendations in whole or in part. The BON may also to dismiss the complaint or discipline the Respondent in accordance with regulatory practices, assuming the BON finds that a violation of the ULA has occurred. Such discipline may include withholding renewal of a license; suspension of a license; revocation of a license; probation of a license; requiring remedial education or treatment; enhanced monitoring, censure or reprimand; compliance with conditions of probation or suspension for a specific period of time; payment of a fine; corrective action, as specified by the BON; or a refund to the consumer of fees that were billed to and collected by the licensee. *See* NMSA 1978, Section 61-1-3 (D through N). It is the ultimate responsibility of the BON to render a decision. NMSA 1978, Section 61-1-13. The recommendation of discipline as set forth herein is based on the record before the Hearing Officer and the Nursing and Health Care Related Providers Disciplinary Philosophy. *See* Regulation 16.12.12.8 NMAC (2021).

Beginning with the disciplinary philosophy, the BON aspires to operate its disciplinary program "with the ultimate goals of protecting the citizens of New Mexico and ensuring professionalism in the nursing profession." Regulation 16.12.12.8 NMAC (2021). A nurse who does not pose a real or potential danger to the public can be considered for a remedial program to treat and correct the unsafe behavior. *Id.* However, the BON in every case may consider denial, suspension, or revocation of a license. *Id.*

At the hearing, the Respondent urged the hearing officer to make a recommendation that she take blood screening tests for drugs, but urged the hearing officer to recommend no discipline as any discipline would have repercussions in her home state of Texas and would ruin her career. Counsel for BON, urged that the hearing officer recommend a suspension of the Respondent's license to practice in New Mexico.

The Respondent made a habit of pulling out medications when there were no doctor's orders for the medications. This practice is beyond the scope of a nursing license. The Respondent's behavior resulted in billing charges to patients for medications not ordered nor administered. There is economic harm here, however, the billing charges were not entered into evidence, so the final balance of improperly billed charges is unknown. The Respondent asserted that no patients were harmed, but Respondent does not appreciate the gravity of the behavior she exhibited. The Hearing Officer's recommends that the BON order reimbursement of the improperly billed charges, not to exceed $1,000.00 or other reasonable amount and to suspend Respondent's professional license, with probation to include a regimen of random drug testing, counseling, and completion of the diversion program.

Ignacio V. Gallegos
Administrative Law Judge
Administrative Hearings Office
Post Office Box 6400
Santa Fe, NM 87502

CERTIFICATE OF SERVICE

I hereby certify that I delivered the foregoing Hearing Officer Report and Recommendation of Discipline to the parties listed below this 2nd day of January 2025 in the following manner:

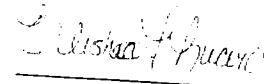
E -mail and Certified Mail:

Winifred Powers, RN # 779320

Cert Mail # 7022 2410 0002 2915 9402

E-mail:

Christopher Sturgess
Counsel for the Board of Nursing
New Mexico Board of Nursing
6301 Indian School NE, Suite 710
Albuquerque, NM 87110
Christopher.sturgess@bon.nm.gov



Elishia Lucero
Paralegal
Administrative Hearings Office
Post Office Box 6400
Santa Fe, NM 87502
elishia.lucero@aho.nm.gov
tax.pleadings@aho.nm.gov