



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.
Patricia P. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 577672 §
issued to TINA DAWN HUDSON BAGGETT § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of TINA DAWN HUDSON BAGGETT, Registered Nurse License Number 577672, hereinafter referred to as Respondent.

An informal conference was held on January 4, 2011, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was represented by Dale Frisby, Attorney at Law. In attendance were Bonnie Cone, MSN, RN, Nursing Practice Consultant, Executive Director's Designee; Kyle Hensley, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Toni Frizell, RN, CNOR, Investigator.

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 is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received an Associate Degree in Nursing from North Central Texas College, Gainesville, Texas, on May 1, 1991. Respondent received a Baccalaureate Degree in Nursing from Texas Christian University, Forth Worth, Texas in 2005. Respondent was licensed to practice professional nursing in the State of Texas on March 17, 1992.
5. Respondent's nursing employment history includes:

3/1992 - 1994 Unknown

Respondent's nursing employment history continued:

1995 - 1997	Director of Nursing	IHS Wichita Falls Wichita Falls, Texas
5/1997 - 11/1997	Consultant	Texhoma Christian Care Center Wichita Falls, Texas
12/1997 - 2002	Consultant	Senior Living Properties Arlington, Texas
2002 - 2005	Clinical Education Specialist	Presbyterian Hospital Dallas Dallas, Texas
2005 - 5/2008	Regional Healthcare Manager	Brookdale Senior Living Milwaukee, Wisconsin
6/08 - 2/2009	Regional Director	Silverado Senior Living San Juan Capistrano, California
3/2009 - 11/2009	Chief Nurse Officer	Doctors Diagnostic Hospital Cleveland, Texas
12/2009 - 2/2010	Interim Chief Executive Officer	Doctors Diagnostic Hospital Cleveland, Texas
3/2010 - 10/2010	Director of Medical Surgical/ICU	Cleveland Regional Medical Center Cleveland, Texas
11/2010 - Present	Staff Nurse	St. Michael's 24 Hour Emergency Room through Pro Health Staffing Houston, Texas

6. At the time of the initial incident, Respondent was employed as a Chief Nurse Officer with Doctors Diagnostic Hospital, Cleveland, Texas, and had been in this position for six (6) months.
7. On or about September 10, 2009, while employed as the Chief Nursing Officer with Doctors Diagnostic Hospital, Cleveland, Texas, and working as the Circulating Operating Room Registered Nurse, Respondent failed to ensure an accurate sponge count was performed on Patient Medical Record Number 20100003707, Case Number 9042, prior to closing the surgical wound. Consequently, a sponge was retained in the patient. An X-Ray taken two (2) days after surgery showed a band-like radiopaque structure projecting over the patient's mid-abdomen. The patient was discharged despite the radiologist's recommendation for additional diagnostic x-rays. The patient was readmitted three (3) weeks later with a seven (7) centimeter abscess due to a foreign object. The foreign object by x-ray appeared to be a

retained surgical sponge. A second surgery was necessary to remove the retained sponge. After discharge from the second surgery, the patient developed blood clots from his ankle to his upper right thigh and required a third admission to the hospital for the administration of blood thinners. Respondent's conduct exposed the patient unnecessarily to a risk of harm from failure to account for all items used during the surgical procedure, which resulted in a foreign item being left in the patient. In addition, the subsequent care givers would have relied on an inaccurate report while providing further care to the patient.

8. On or about October 27, 2009, while employed as the Chief Nursing Officer with Doctors Diagnostic Hospital, Cleveland, Texas, Respondent documented additions to the surgical record of the aforementioned Patient Medical Record Number 20100003707, Case Number 9042, for September 10, 2009, including that:

- The surgeon was notified of correct instrument, sponge, and needle counts;
- The emoelectro-cautery pad was removed;
- Pressure areas were checked; and
- The patient was transferred from the operating room bed by roller and was transported to the Post Anesthesia Care Unit.

Respondent did not document that the additions were late entries, as required. Respondent's conduct resulted in an inaccurate medical record, and was likely to injure the patient in that subsequent care givers would have relied on an accurate report while providing further care to the patient.

9. In response to the incidents in Finding of Facts Numbers Seven (7) and Eight (8), Respondent states that all counts were performed and correct, even though the initial documentation didn't reflect that the sponge, instrument, and needle counts were correct or that report to the surgeon of the correct counts was given. According to Respondent, she noticed that the record was not complete after the patient returned to the hospital with the retained sponge and admits to altering the documentation. Respondent admits failing to include "late entry" in her charting.

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 of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A), (1)(B), (1)(D), (1)(M)&(3) and 22 TEX. ADMIN. CODE §217.12(1)(A), (1)(B), (1)(C), (4), (6)(A)&(6)(H).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 577672, heretofore issued to TINA DAWN HUDSON BAGGETT, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS AND A FINE, and RESPONDENT SHALL 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.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It 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. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: 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. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*

<http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete 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 program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: <http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary>.*

(4) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars (\$500.00). RESPONDENT SHALL pay this fine 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.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge,

if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(6) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) RESPONDENT SHALL NOT practice as a nurse in any operating room area for two (2) years of employment as a nurse.

(8) RESPONDENT SHALL be supervised by a Registered 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 for the exception of current employment with St. Michael's 24 Hour Emergency Room through Pro Health Staffing. Multiple employers are prohibited.

(9) 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 Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) years of employment as a nurse.

IT IS FURTHER AGREED, that 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 shall be eligible for nurse licensure compact privileges, if any.

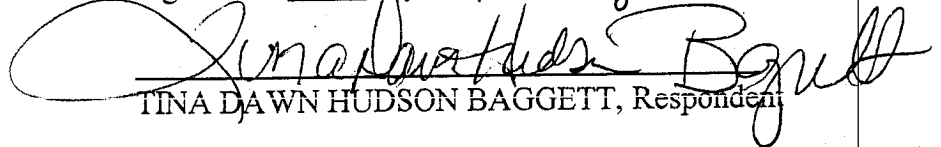
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RESPONDENT'S CERTIFICATION

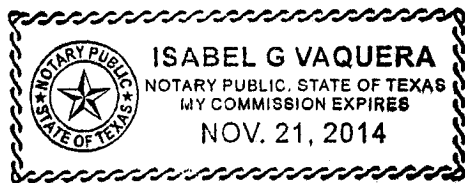
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, 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 revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

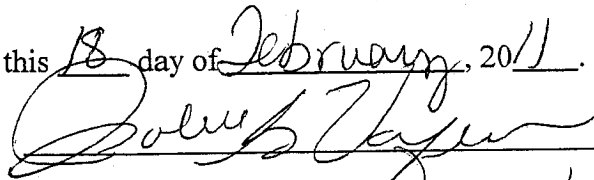
Signed this 18 day of February, 2011.


TINA DAWN HUDSON BAGGETT, Respondent

Sworn to and subscribed before me this 18 day of February, 2011.

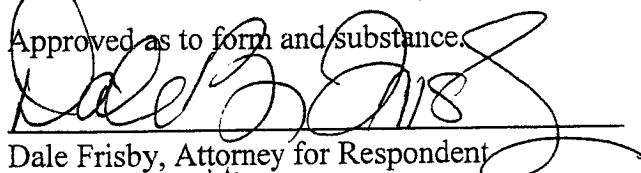
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Notary Public in and for the State of 11/21/14

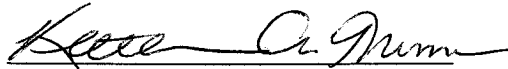
Approved as to form and substance.


Dale Frisby, Attorney for Respondent

Signed this 18th day of February, 2011.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 18th day of February, 2011, by TINA DAWN HUDSON BAGGETT, Registered Nurse License Number 577672, and said Order is final.

Effective this 28th day of April, 2011.

A handwritten signature in cursive script, appearing to read "Katherine A. Thomas".

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