BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse License Number 527129 issued to ANNETTE RAMON GONZALEZ	§ §	AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boa considered the matter of ANNETTE RAMON GONZALEZ, Registered Nurse License Num... 527129, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order offered on May 11, 2008, by Katherine A. Thomas, MN, RN, Executive Director.

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.

2. Respondent waived representation by counsel, informal conference, 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 The University of Texas-Pan American, Edinburg, Texas, on May 1, 1985. Respondent was licensed to practice professional nursing in the State of Texas on August 28, 1985.

5. Respondent's professional nursing employment history includes:

9/85 to 11/86	RN McAllen Medical Center McAllen, Texas

Respondent's professional nursing employment history continued:

11/86 to 10/89	RN, Case Manager Cohr's Home Health McAllen, Texas
Unknown to 11/89	RN, Case Manager Regency Home Health McAllen, Texas
1989 to 1992	RN, Program Director Lower Rio Grande Development Council Area Agency on Aging McAllen, Texas
1989 to 1992	RN Village Care Nursing Home McAllen, Texas
1989 to 1992	RN McAllen Nursing Center McAllen, Texas
1992 to 1993	RN, School Nurse Hidalgo Independent School District Hidalgo, Texas
1993 to 1994	RN Valley Home Health
6/94 to 7/96	RN Vital Health Care, Inc. Edinburg, Texas
8/96 to 7/99	RN Optimum Health Care
8/99 to 12/99	Unknown
1/00 to 5/04	RN Vital Home Care, Inc. Edinburg, Texas
5/04 to 5/06	RN, Director of Nursing Loving Touch Home Health Pharr, Texas
6/06 to Present	Unknown

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as the Director of Nursing (DON) with Loving Touch Home Health, Pharr, Texas, and had been in this position for one (1) year and six (6) months.

7. On or about November 13, 2005, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to discharge Patient Medical Record Number LT118 from home health service, as ordered by the physician, which would have required that a comprehensive discharge assessment be completed. As a result, another nurse was required to perform the comprehensive discharge assessment, more than a month later, and staff nurses continued to attempt to provide skilled nursing visits. Respondent's conduct could have resulted in the patient being billed by the agency for unauthorized services.

8. On or about January 31, 2006, through March 14, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to timely submit to the agency documentation of missed visits for Patient Medical Record Number LT167. Respondent did not document the missed visits in the medical record until five (5) months after her employment with the agency had ceased and more than four (4) months after the patient had been discharged from the agency, and Respondent did not indicate that the entries regarding the missed visits were documented as late entries. Respondent's conduct resulted in an inaccurate medical record, and was likely to injure the patient in that other care givers would have relied on her documentation while providing further care to the patient.

9. On or about February 25, 2006, through April 25, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to ensure Patient Medical Record Number LT170 had skilled nurse visits performed as ordered. Although the physician revised the order for the number of skilled nurse visits per week, only three skilled nursing visits were completed besides the initial start-of-care assessment and the discharge assessment. Respondent's conduct was likely to injure the patient from failure to have assessments and treatments provided as ordered by the physician, and could have resulted in missed changes in the patient's medical status, which may have required further interventions.

10. On or about March 1, 2006, through April 29, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to perform and/or ensure that skilled nurse visits and care were provided to Patient Medical Record Number LT122, as ordered by the physician. One missed visit was reported during the first week as scheduled, and only one visit was performed the following week. Thereafter, the only documentation of skilled visits was multiple visits missed, but the patient progressed well and was discharged from services on April 29, 2006. Respondent's conduct was likely to injure the patient in that nursing assessments and interventions were not being carried out as ordered, which could have resulted in missed changes in the patient's medical status and which may have required further interventions.

11. On or about March 27, 2006, through May 31, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed twice to timely document two (2) different physician's orders for Patient Medical Record Number LT064-2, as follows:

- Suspend home health services, effective March 27, 2006; and
- Discharge from home health services, effective April 17, 2006.

Although Respondent's employment with the agency ceased on May 31, 2006, she did not document the orders until nearly four (4) months later. Respondent's conduct resulted in an inaccurate medical record and was likely to injure the patient in that subsequent care givers would not have completed information on which to base their care decisions.

12. On or about April 6, 2006, through May 31, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to perform and/or ensure that skilled nurse visits and assessments were provided to Patient Medical Record Number LT176, as ordered. Although the Staff LVN assigned to provide skilled care to the patient notified Respondent that he repeatedly could not locate the patient, Respondent failed to notify the physician that the skilled visits were not being performed. Consequently, the patient received only the initial, start-of-care assessment and skilled nurse visit. Respondent's conduct was likely to injure the patient from failure to ensure nursing assessments and interventions were not performed, as ordered by the physician. Additionally, Respondent's conduct deprived the physician of vital information on which to base further medical care.

13. On or about April 17, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to accurately document the date of the last actual patient in-home visit on the discharge assessment for Patient Medical Record Number LT064-2. Although the assessment was not performed in person, Respondent documented that she performed an in-home visit on that date, yet documented on the discharge summary that the discharge was done verbally because the patient was out of town. Respondent's conduct resulted in an inaccurate medical record, and subsequent caregivers would have relied on her documentation.

14. On or about April 29, 2006, while employed with Loving Touch Home Health, Pharr, Texas, Respondent failed to accurately document the date of the last actual in-home visit on a discharge assessment for Patient Medical Record Number LT122. Although the assessment was not performed in person, Respondent documented that she performed an in-home visit on that date, yet documented on the discharge notice that the patient refused the discharge visit. Respondent's conduct resulted in an inaccurate medical record, and subsequent caregivers would have relied on her documentation.

15. In response to the incidents in Findings of Fact Numbers Seven (7) through Fourteen (14), Respondent states that:

- Regarding Patient Medical Record Number LT118 , the discharge was scheduled to another nurse who performed the visit and that the scheduler had been instructed to cease scheduling the patient as ordered by the physician;
- Regarding Patient Medical Record Number LT167, Respondent admits that she failed to document the entries as late entries;

- Regarding Patient Medical Record Number LT170, the physician was aware of the missed visits due to chemotherapy and physical therapy appointments;
- Regarding Patient Medical Record Number LT122, the assigned nurse performed three (3) skilled nurse visits, the patient was discharged verbally, without being billed, due to refusal of home visits, and that an unexpected discharge can be based upon the last qualified visit, according to the Texas Department of Aging and Disability Services rules;
- Regarding Patient Medical Record Number LT064-2, she did complete the chart documentation on September 23, 2006, at the request of the owner, and that an unexpected discharge can be based upon the last qualified visit, according to the Texas Department of Aging and Disability Services rules; and
- Regarding Patient Medical Record Number LT176, Respondent denied failing to perform/ensure visits were performed, but admits that she did not see continuous communication with the physician documented in the medical record.

Overall, Respondent states that her efforts to complete late documentation were at the request of the owner and that the owner became threatening. Respondent indicates that she had also contacted the Texas Board of Nursing and the Texas Department of Aging and Disability Services regarding her issues.

16. The general standards of nursing are that while an unexpected discharge can be based on the last qualified visit, whether by a registered nurse, physical therapist, occupational therapist, or speech therapist, it must be clearly documented that the prior qualified visit was the basis for the discharge assessment and that it is unacceptable to document the date of the last home visit as the same date as the discharge date if in fact a home visit was not performed on that date.

17. Charges were filed on December 12, 2007.

18. Charges were mailed to Respondent at her address of record on December 14, 2007.

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 violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 217.11(1)(B),(1)(C),(1)(D),(1)(M),(1)(P)&(3)(A)and 217.12(1)(B),(1)(C)&(4).

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 527129, heretofore issued to ANNETTE RAMON GONZALEZ, including revocation of Respondent's license to practice professional 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 REMEDIAL EDUCATION WITH A FINE , and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code §§301.001 *et seq*., the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq*. and this Order.

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to ANNETTE RAMON GONZALEZ to the office of the Texas Board of Nursing within ten (10) days of the date of ratification of this Order for appropriate notation.

(2) 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) contact 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/disciplinary action.*

(3) 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/disciplinary action.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Pre-Survey Conference Computer-Based Training" for Home and Community Support Services Agencies, a six (6) module program which provides a general overview of state and federal licensure rules regarding home health care and which is presented by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the Pre-Survey Conference Attendance Verification form to the Board's office. 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 website: http://www.dads.state.tx.us/providers/hcssa/cbt/.*

(5) 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, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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 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 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 revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 22nd day of July, 2008.

Annette Ramon Gonzalez RN

ANNETTE RAMON GONZALEZ, Respondent

Sworn to and subscribed before me this 22nd day of July, 2008.

SEAL

KARA N. VELA NOTARY PUBLIC STATE OF TEXAS EXPIRES 09-21-2010

Kara N. Vela

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 22nd day of July, 2008, by ANNETTE RAMON GONZALEZ, Registered Nurse License Number 527129, and said Order is final.

Effective this 29th day of July, 2008.

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